# How Technology Enhances MIH Services

**White Paper**

HealthCall, LLC

Whether you're starting your community's first MIH program or looking to expand a program that's been running for years, it's important to examine the technology you use to organize your data and automate your tasks. What do you use to organize your referrals? When you visit a patient, how do you pull the information you need to provide quality care? How do you collect data on your successes, and how do you create reports that prove your program's value? These aren't arbitrary questions, they demonstrate the three ways technology enhances MIH. In this article we explore each category: how technology improves operational efficiency, how it improves quality of care, and how it supports sustainability and funding. There is no universal solution for MIH, but once you understand what each individual tool can do for you, you can build a toolset matched to your program's unique needs.

## Improving Operational Efficiency

### Telehealth Helps Avoid Unnecessary Drives

When your MIH program receives a referral, your team needs a way to follow up: a way to assess the patient's situation, identify emerging risks, and determine next steps. One solution is to drive there in person, certainly effective, but it limits the population you work with by the number of vehicles you have, and the amount of time you can spend driving to location. Telehealth can allow your team to follow up on a referral without a drive. You can then use your virtual conversation to determine whether this patient requires an urgent response, a scheduled visit, or even a referral to a different service. This workflow doesn't just free up your vehicles, less time spent traveling means your team has more availability to work with other patients. Of course, low-friction access is vital; after all, telehealth is far less efficient when patients must install an application, create an account and troubleshoot a password before your conversation. Browser-based telehealth can allow a patient to join a secure connection using a simple text or email link, allowing seamless virtual conversations even with populations that may have older devices, limited connectivity, or little experience with digital tools. (HealthCall One-Click Telehealth) These benefits are particularly helpful to rural communities, where local healthcare is already stretched thin, and a single visit from your team may see you driving for an hour or more. Using telehealth, a brief virtual interaction can provide critical information before you decide how to commit your scarce field resources.

### Automated Outreach Helps Manage Large Populations

If your team works with a larger patient population, focusing on chronic conditions that may worsen unexpectedly, you may find yourself challenged to determine who needs your help on any given day. Following up with each patient frequently would take more time than you have, but a less frequent schedule diminishes your ability to catch problems at an early stage, before it's bad enough that the patient calls in. An automated assessment platform can shoulder the burden of frequently checking in with patients. Whether sent via call, text or email, an automated assessment can collect any data the patient is able to report. If the platform also features customizable alerts, your team can easily find those patients who report concerning symptoms, and reach out to them to address the problem.

Of course, more alerts does not automatically mean better care. Alert thresholds should be customizable, allowing you to set default values for the population in general and specific values for patients with special cases. The alerts should also connect to a defined workflow which identifies who receives the alert, how quickly they should respond, and what follow-up actions they should take.

#### Client Example: Managing by Exception in Plano

Plano Fire-Rescue used automated assessments to monitor changes in patient health between in-home visits. Their system evaluated patients' responses against thresholds customized to those patients' needs, and notified the team when an answer fell outside those thresholds. This created a manage-by-exception workflow: rather than manually contacting every patient with the same frequency, the team directed more attention toward the patients showing increased risk. (HealthCall Plano Case Study) This demonstrates one of the most important ways a tool can enhance your MIH program: automation. Automatic workflows can handle the routine, repetitive tasks that otherwise occupy your time, while escalating any situation that actually requires personal expertise.

### Digital Assessments Allow Seamless Data Collection

While data collection is primarily useful for securing funding and internal review, it's worth noting that the right tools can also save you significant time. Whether you're spending hours compiling grant-required spreadsheets or filling out redundant forms on every home visit, collecting structured, standardized data can be a heavy burden for your team. A flexible, digital assessment allows you to collect standardized information as a part of regular care. Regardless of your grant requirements or funding partnerships, the relevant data collection can be integrated into your team's normal workflows. Whenever a paramedic responds to an emergency, visits a patient in the home or even conducts a virtual visit, a robust assessment platform will make sure they collect all the information their program needs. Meanwhile, a robust reporting platform will automatically compile that information into reports for their funding partners, so the paramedics can spend less time crunching numbers, and more time helping patients.

#### Client Example: Reports as Byproduct of Care in Lee County

The community paramedicine program of Lee County offers a practical example. Its grant required the paramedics to complete a specific set of assessments; by embedding those assessments into the team's SMART Charts, paramedics could complete them within their ordinary clinical workflow instead of maintaining separate paper forms. The information needed for reporting became a byproduct of delivering care. (HealthCall Lee County Case Study)

## Improving Quality of Care

### Before the Visit: Automated Outreach and Longitudinal Records Help Your Team Prepare

Even when you're not actively working with a patient, it can be useful to track key symptoms, so that when a problem does arrive your team can tackle it with full context. Automated outreach systems (like HealthCall's APR assistant) can collect the metrics you need by call, text message or email. (HealthCall Patient Engagement) For more precise readings, remote patient monitoring systems (RPM) allow your team to link a health device with a patient's digital record, so that the readings from their scale, blood pressure cuff and heart rate monitor can contribute to the whole picture of their

health. Indeed, the U.S. Department of Health and Human Services notes that longitudinal RPM data can provide a fuller picture than an occasional office reading, and can help providers recognize changes and make care decisions sooner. (HHS Telehealth) This is best paired with a longitudinal patient record, linking each assessment together for easy reference. A longitudinal record is also vital for establishing and preserving rapport, as it allows different teams to benefit from each-others' knowledge of the patient's history and preferences. Especially useful is a record that allows for highlighted, high-priority notes; with this feature, every team who works with the patient is aware of any critical factors that could derail the relationship, or endanger the team member.

### Client Example: Seeing Change Across Encounters in Tampa Bay

The Crisis Center of Tampa Bay illustrates why longitudinal context matters. Before adopting a digital care-coordination platform, this community paramedicine team relied heavily on handwritten narratives, printed questionnaires, and information transferred through email. After the program began using longitudinal charting and structured care plans, clinicians had a centralized place to review vital signs, weight changes, and other information from previous encounters. During the first six months, the program reported an 87% reduction in emergency room visits and an 85% reduction in inpatient admissions. In one case, a concerning change in a patient's weight became visible to the paramedic, who prevented a costly visit to the hospital by coordinating with the patient's physician and tracking the patient's responses through their follow-up visits. (HealthCall Tampa Bay Case Study)

## During the Visit: Decision-Support Tools and Telehealth Give You the Information You Need

While it is vital to be prepared for visiting a patient, it's impossible to predict everything that will be relevant to their situation. A key feature for any documentation platform is the ability to bring it with you on the go. Whether it be a browser-based solution or an internet-connected app, a tool that gives you direct access to the patient's record is essential for handling the unexpected. At the same time, the tool should make the standard workflow quick and intuitive, to avoid stalling the visit and damaging your rapport. When collecting new data, it's also quite useful to see current readings in the context of the patient's history. Some tools show the patient's previous answers alongside the current assessment; some add the patient's answers to a graph to uncover trends; some allow for configurable thresholds that alert the paramedic when the latest answer merits concern. All of these tools support the paramedic's decision-making as they stay alert for meaningful changes in the patient's condition. (HealthCall MIH Platform) Telehealth is another useful tool for home visits, as it allows other members of the patient's support team to participate and lend their expertise. Some integrated platforms can even transmit patient monitor data over the call. (HealthCall Streaming Vitals) This is useful for both unexpected symptoms and routine checkins, especially if certain caregivers are rarely able to see the patient in-person. As mentioned earlier, low-friction access is important to avoid stalling the visit and frustrating your patient; if the parties involved struggle with application or account trouble-shooting, consider a browser-based solution that allows people to join using a simple text or email link. (HealthCall One-Click Telehealth)

## After the Visit: Data Sharing and Shared Tasks Help Coordinate Community Resources

MIH is rarely a case of one organization acting alone; rather, a program may coordinate with hospitals, law enforcement, social workers, shelters, food programs and other elements of the

community. Some tools can enhance your program greatly by helping all these parties stay on the same page. Look for patient record systems with secure data sharing and customizable access permissions. These allow you to share an operational picture of the patient, allowing partners to add notes and assessments to the patient's unified record, but still keeping some parts of that record off-limits for the sake of HIPAA. For example, HealthCall's Community Care Network can allow an MIH team to share select patient details with a corrections center. This means that if the corrections center works with the patient again, the MIH team can see their notes and assessments in real time. Meanwhile, the corrections center has access to the patient's up-to-date record, albeit limited for privacy and HIPAA compliance. (HealthCall MIH Platform) This kind of collaboration network is further enhanced by assignable tasks. With this feature you can reach out to members of a patient's care network for specific aid, leaving customized instructions and receiving notice when they mark the task complete. You can even use this to request grant-required feedback from your partners, assigning them standardized assessments regarding their work with the patient.

## Supporting Sustainability and Funding

### Look Beyond Incident Reports

The nature of MIH is to look beyond the crisis, proactively addressing the underlying causes of a patient's chronic conditions. While the classic emergency incident report is well-supported, with many data collection and reporting tools, your team may struggle to capture the complexity of their work with such a narrow set of assessments. For example: a home visit in MIH may involve taking vitals, administering a fall risk assessment, medication reconciliation, chronic disease education, establishing mental or behavioral health needs, assessing caregiver capacity, evaluating the patient's ability to follow their care plan, and/or addressing problems with food insecurity, transportation and housing. A classic emergency incident report allows for only a small sliver of those possibilities. Look for a documentation platform that supports a wide variety of proven, standardized assessments, and allows your team easy access to whatever assessments they need in a given encounter. The ability to create your own customized assessments is also extremely valuable, as it allows all your data entry (no matter how niche) to happen in the same interface. HealthCall SMART Charts, for example, can combine standardized and customized assessments, as well as bundling related documentation, tying directly into the HealthCall reporting platform, and many other features. (HealthCall SMART Charts)

### Meeting Increased Demands for Reporting under RHT

In the world of MIH, funding and reporting have gone hand-in-hand for years, but recent developments have put even more emphasis on a program's ability to prove its value. Running through 2030, the Rural Health Transformation Program is a federal effort to raise health outcomes in rural areas throughout America. Its methods and goals align well with MIH, including an emphasis on preventative care and following up with patients in the home and the community. Each state has or will receive millions of dollars to fund RHT programs, and MIH will likely play a significant role, but continued funding for their programs is not a guarantee. Under RHT, state performance is tied to a structured, multi-year funding model. CMS will assess progress for each budget period, and adjust funding based on whether the state meets certain milestones and policy commitments. If the state falls short, funding may decrease to zero, and CMS may recover funds it previously awarded. (Rural Health Transformation) This creates a very different risk environment. For MIH programs working

with RHT funds, having an efficient and reliable reporting platform can no longer be an afterthought, it must be a core requirement.

### Standardized Assessments Help Every Program

Beyond submitting results to funding partners, a reporting platform is useful for ongoing improvement, both for your own program, and for MIH as whole. Keep an eye out for reporting platforms that can track the progress of your own workflows. Just as some metrics can reveal a patient's developing health problems, others can show where your team faces bottlenecks; which team members need more training or support; which workflows are running smoothly, and which need adjusting. Back on the patient side, reporting platforms that include standardized health assessments can benefit not just your team, but the entire MIH community. After all, the more research supports MIH as an effective form of proactive care, the easier it becomes to set up and fund new MIH programs, but while existing research is promising, historic outcome measures vary considerably. For example: a 2023 meta-analysis found that MIH-CP programs were associated with a lower risk of emergency department visits. However, a subsequent systematic review noted substantial differences in study methods and the metrics programs used to evaluate success. (PubMed) To help create a clearer, more thorough understanding of MIH, look for a reporting platform that supports proven, standardized versions of the assessments your team collects.

## There Is No Universal MIH Toolset

There is no universal MIH toolset because there is no universal MIH program. A program helping frequent 911 users may prioritize longitudinal patient records and support for social drivers of health. A post-discharge program may look for medication reconciliation tools and standardized, disease-specific assessments. A rural program may rely on telehealth to offset transportation difficulties; an urban program may rely on automated outreach to help manage their large population. Even within a single program you may have varied needs. Patients have different levels of independence, health literacy, and access to technology. One patient may respond reliably to a daily text, while another needs a family member to participate. A high-risk patient may benefit from remote monitoring with in-home devices; another may need only scheduled telephone contact and periodic assessments. A capable MIH platform will support this variety. Standard workflows should be customizable on a patient-by-patient basis, and your team should have easy access to the features they need without digging through a pile of the features they don't. When you need a feature the platform doesn't have, they should work with you to create a solution. And no matter which of their tools you use, a capable platform should support the human expertise, and human connections, at the heart of MIH.