

# Mobile Integrated Health (MIH) Proposal Packet

A Collaborative Initiative Between

Orcas Island Fire & Rescue (OIFR)



And

Orcas Island Health Care District (OIHCD)

Orcas Island  
Health Care  
District

## **Executive Summary:** **Mobile Integrated Health (MIH) Program, a OIFR + OIHCD Partnership**

### **Background**

Orcas Island faces unique health care challenges stemming from its geographic isolation, limited on-island medical resources, and reliance on off-island emergency transport for higher levels of care. When on-island medical resources are unavailable or urgent medical needs arise, patients often require costly and/or logistically complex air transport to mainland facilities. These emergency flights are not only financially burdensome for patients, insurers, and public systems, but they also pose health and safety risks associated with delayed access to appropriate care and transport limitations due to weather or availability.

At the same time, many of these emergency transports stem from preventable conditions or could be avoided through timely, coordinated, and community-based interventions. Limited access to primary and specialty care, lack of on-island care resources, inconsistent follow-up after hospital discharge, and gaps in chronic disease management contribute to a cycle of crisis-driven care rather than proactive health maintenance.

### **Proposed Solution**

A Mobile Integrated Health (MIH) program for Orcas Island offers a community-centered solution. By leveraging trained health care professionals—MIH services can bridge the gaps between emergency response, primary care, and social services. The program would provide in-home assessments, preventive care, chronic disease monitoring, referral and warm hand-offs to social supports, and coordinated follow-up after hospital visits or emergency calls.

### **Anticipated Impact**

- **Reduce unnecessary emergency flight transports** through early intervention and local treatment when appropriate and available.
- **Enhance care coordination** by connecting patients with on-island and mainland providers, social services and community resources, improving continuity across care settings.
- **Improve preventative and chronic care management**, supporting better health outcomes and reducing the overall cost and strain on the health system.

Given Orcas Island's isolation, limited medical facilities, limited emergency transport options, and aging population, a Mobile Integrated Health program represents an essential step toward a more sustainable, resilient health care model that works for the most vulnerable in our community.

### **Goals in Year 1 of an Orcas Island Mobile Integrated Health Program**

#### **Phase 1: Start-up (November '25 – April '26)**

- Develop robust program infrastructure, including policies, procedures, and protocols (SOPs), criteria for enrollment and disenrollment, referral pathways, the purchase and build-out of a data-reporting system, finalizing of year 1 Key Performance Indicators (KPI) metrics and plan for data collection and reporting, and more as outlined in Appendix A, p.14: FINEST Framework Planning Outline.

## **Phase 2: Pilot Launch (May 2026 – December 2026)**

- **Establish clear success metrics and baseline data collection** to ensure outcomes can be credibly evaluated. Specifically, define pre- and post comparisons to quantify improvements and associated benefits to the community for medical flight transport.
- **Collect, analyze, and publicly report program data** to demonstrate measurable impact on community health needs, cost trends, and system utilization, creating a transparent and evidence-based case for future community investment in the program.
- **Provide in-home medical and social support for chronic disease management, post-discharge follow-up, and behavioral health**, documenting outcomes that reflect both improved patient well-being and reduced reliance on higher-acuity care.
- **Expand access to care and essential services for vulnerable and mobility-challenged residents**, measuring reach, equity, and service effectiveness.
- **Strengthen coordination and referrals across island health resources**, tracking improvements in continuity of care, system efficiency, and resource alignment.
- **Establish a clearly defined long-term funding strategy prior to pilot completion**, ensuring continuity of services and maintaining community trust once the program becomes operational and relied upon by Islanders.

### **OIFR Commitments**

- \$25,000 in direct funding.
- LifePack 15 Cardiac Monitor, MIH equipment, MIH response SUV, and Toughbook laptop.
- Train EMTs to conduct MIH intake and resource coordination.
- Train all OIFR field staff in the purpose of the MIH program and when and how to refer patients into the program.
- Employ/Contract additional MIH medical staff in Phase 2, according to the availability of funds.
- Provide administrative oversight.
- Collect, collate and share program data.
- Develop a shared community engagement and communication plan with OIHCD to promote the program.

### **OIHCD Commitments**

- \$76,000 in direct funding.
- Provide project management support via the OIHCD Community Health Project Manager. Maximum 10 hours/week support in the pilot year of the program to assist in program build out.
- Ensure program evaluation and fiscal accountability via participation in the Joint Oversight Committee.
- Develop a shared community engagement and communication plan with OIHCD to promote the program.

## **Benefits**

- Data-driven reporting to develop a credible guide for program evolution and the identification and/or development of additional resources.
- Improved access to healthcare at home for homebound adults and other vulnerable individuals.
- Reduced strain on EMS and emergency departments.
- Expanded behavioral health support through resource coordination that addresses social determinants of health.
- Stronger partnership between OIFR and OIHCD.
- Filling healthcare gaps in rural medicine.

**Full Proposal**  
**Mobile Integrated Health (MIH)**  
*a Collaboration between Orcas Island Health Care District (OIHCD) & Orcas  
Island Fire & Rescue (OIFR)*  
**Fall 2025**

**Program Objectives**

1. Improve access to care for homebound and underserved residents.
2. Provide early intervention through intake, screening, and referral.
3. Enhance chronic condition management to prevent hospitalizations.
4. Support behavioral health and recovery through care coordination.
5. Strengthen data-driven outcomes through secure reporting and evaluation.

**Objective 1: Strengthen data-driven outcomes through secure reporting and evaluation.**

**Performance Measures:**

- Implementation of a standardized, HIPAA-compliant data tracking and reporting system.
- Percentage of MIH encounters documented using standardized data fields.
- Quarterly reports produced summarizing trends in service utilization, patient needs, and outcomes.

Data findings used to inform at least two program adjustments or partnership strategies during the first year.

**Objective 2: Provide early intervention through proactive intake, screening, and referral.**

**Performance Measures:**

- Number of residents receiving health and social needs screenings.
- Percentage of screened individuals referred to appropriate medical, behavioral health, or social services.
- Reduction in non-emergency 911 calls or emergency transports among MIH participants.
- Average time between identification of need and referral follow-up.

**Objective 3: Enhance chronic disease management to reduce preventable hospitalizations and emergency transports.**

**Performance Measures:**

- Number of patients enrolled in chronic condition monitoring or follow-up.
- Percentage of enrolled patients demonstrating improved clinical or self-management outcomes (e.g., medication adherence, symptom control).
- Reduction in repeat emergency transports or hospital readmissions for MIH participants.
- Number of care plans developed and reviewed with primary providers.
- Reduction in falls reported to EMS.

## **Objective 4: Support behavioral health and recovery through coordinated care and connection to resources.**

### **Performance Measures:**

- Number of residents screened for behavioral health or substance use needs.
- Number and type of referrals made to behavioral health or recovery services.
- Percentage of clients with successful connection or follow-up to referred services.
- Patient-reported improvements in stability, recovery, or support satisfaction.

## **Objective 5: Improve access to care for homebound, isolated, and underserved residents.**

### **Performance Measures:**

- Number of home visits and in-community care encounters completed per month.
- Percentage of participants reporting improved access to needed services.
- Number of residents newly engaged with primary or specialty care providers through MIH referrals.
- Average response time from referral to first MIH contact.

## **Target Population: Identification & Enrollment**

### **Patient Profile**

**Demographics:** Typical patients served by the Mobile Integrated Health (MIH) program are adults and older residents of Orcas Island who experience barriers to consistent, coordinated health care. Many live with one or more chronic medical conditions, have limited transportation options, and may face financial or social challenges that make it difficult to access timely medical, behavioral, or preventative care.

**Health Status:** Patients often manage complex conditions such as diabetes, hypertension, heart disease, respiratory illness, or mental health and substance use disorders. Many have recently been discharged from a hospital or emergency visit and are at elevated risk for readmission due to gaps in follow-up care, medication management, or lack of connection to ongoing primary or specialty care as well as social resources.

### **Identification and Referral Process**

**Referral Sources:** Patients are identified internally by EMS, or externally by San Juan County Senior Services, Orcas Community Resource Center or Island-based Primary Care Providers.

### **Referral Process:**

- OIFR refers patients directly to the program based upon internal program enrollment criteria using ESO records management system.
- Clinic or private PCPs, Orcas Island Resource Center, San Juan County Senior Services or Compass Health refer directly to MIH Program, based upon referral guidelines and

methods defined in Phase 1 and communicated to partners within the Community Health Stakeholder Advisory Group (see p.11 for details on Advisory Group).

## Roles & Contributions

### OIFR Commitments

- \$25,000 in direct funding.
- LifePack 15 Cardiac Monitor, MIH equipment, MIH response SUV, and Toughbook laptop.
- Train EMTs to conduct MIH intake and resource coordination.
- Train all OIFR field staff in the purpose of the MIH program and when and how to refer patients into the program.
- Employ/Contract additional MIH medical staff in Phase 2, according to the availability of funds.
- Provide administrative oversight.
- Develop a shared community engagement and communication plan with OIHCD to promote the program.

### OIHCD Commitments

- Fund \$76,000 of Program Year One
- Provide project management support via the OIHCD Community Health Project Manager
- Ensure program evaluation and fiscal accountability via participation in the Joint Oversight Committee.
- Develop a shared community engagement and communication plan with OIHCD to promote the program.

## Staffing Structure

### Phase 1 Program

#### Development Consultant

### Phase 1, Program Startup:

- Significantly responsible for overseeing program infrastructure development, as overviewed in the Implementation Timeline (p 11) with support from OIHCD Community Health Project Manager.

### Phase 2 Program Pilot

#### Lead: Paramedic, RN or *other medical professional*

### Phase 2, Program Launch:

- Medication reconciliation post-hospital discharge
- Chronic disease monitoring (e.g., diabetes, hypertension, CHF)
- Wound care and dressing changes
- Vital signs and symptom assessments for PCP follow-up
- Transitional Care Management (TCM) visits
- Chronic Care Management (CCM) under PCP-directed plans
- Patient and family education on disease and medication management & fall risk mitigation
- Care coordination via MIH software referrals and follow-up tracking
- *Weekly hours of this individual will depend upon funding availability*

**EMT Scope of Services**

- Conducts MIH Program Intake Screening
- Provides referral coordination to local and regional resources (In-home Caregivers, PCP follow-up, OCRC, Senior Services, Behavioral Health supports)
- Provides home visit support alongside Program Lead individually or under supervision.
- Responsible for data collection via the MIH EHR platform

**Staffing Compensation**

**Role / Category**

**Compensation Structure**

**EMS Response (911 Calls)**

**Volunteer EMTs:**

- \$30 per call
- \$20 per drill

**Mobile Integrated Health (MIH) EMTs**

**Hourly Rate: \$25–\$32**

**Program Development Consultant**

**Contracted**

Hourly \$45–\$65; Max billing \$15,000 in year 1

**Program Pilot Lead: Registered Nurse or other Medical Professional**

**Contracted/on-call**

Hourly \$45–\$65; Max billing \$30,000 in year 1 (*pending funding availability*)

**PROGRAM BUDGET: OIFR CONTRIBUTION**

<b>Item</b>	<b>Description / Notes</b>	<b>Estimated Value</b>
<b>Direct Funding</b>	Local agency support	<b>\$25,000</b>
<b>LifePack 15</b>	Cardiac monitor/defibrillator (includes annual maintenance \$2,000)	<b>Included in-kind</b>
<b>MIH Equipment</b>	Field gear and supplies	<b>Included in-kind</b>

<b>SUV Vehicle</b>	Current value ~\$30,000 + annual maintenance and fuel (\$3,000)	<b>\$33,000</b>
<b>Technology</b>	Laptop, cellphone, communication equipment	<b>\$2,000</b>
<b>Total Contribution</b>		<b>\$60,000</b>

#### YEAR 1 (JAN '26-DEC '26) PROGRAM BUDGET

<b>Category</b>	<b>Description</b>	<b>Estimated Cost</b>
<b>Contract/On-Call</b>	Program Pilot Lead (RN or other medical professional) — <i>The hiring of this role dependent upon obtaining additional funding during Phase 1</i>	<b>\$32,500</b>
<b>Contract/On-Call</b>	Program Pilot Nurse Support Staff	<b>\$15,000</b>
<b>EMT MIH Hourly</b>	6–12 hrs/week @ ~\$28/hour; March '26-Dec '26	<b>\$15,000</b>
<b>Training – EMT and/or other staff</b>	Credentialing, continuing education, and MIH-specific training	<b>\$5,000</b>
<b>Program Software</b>	MIH data platform, configuration, and support (\$14k subsequent years)	<b>\$21,000</b>
<b>Medical Supplies &amp; Consumables</b>	Field kits, PPE, and replenishable materials	<b>\$8,000</b>
<b>Training Materials</b>	Manuals, educational resources, and certification materials	<b>\$5,000</b>
<b>Administration &amp; Reporting</b>	Program coordination, data management, and evaluation support	<b>\$7,000</b>
<b>Contingency (≈5%)</b>	Unanticipated expenses or cost adjustments	<b>\$5,000</b>
<b>Total Budget</b>	—	<b>\$111,000</b>

**YEAR 1 BUDGET SUMMARY: UNMET NEED**

Component	Amount (\$)	Type	Notes
OIFR cash support	\$25,000	Contribution	Already committed
Total Year 1 program cost	\$111,000	—	Complete funding package
<i>External or additional funding</i>	<i>\$86,000</i>	<i>Required</i>	<i>To reach full Year 1 budget</i>

*If the Orcas Health Care District is able to contribute \$76,000 to this program in 2026, the remaining budget shortfall will be met with AWP/PHD Grant. Beyond addressing the \$111,000 budget shortfall, we'll seek additional funds to expand the medical professional Program Lead role in Year 1.*

**YEAR 2 BUDGET SUMMARY: UNMET NEED**

Component	Amount (\$)	Type	Notes
OIFR cash support*	\$25,000	Contribution	Already committed
Total Year 2 program cost	\$123,475	—	Complete funding package
<i>External or additional funding</i>	<i>\$98,475</i>	<i>Required</i>	<i>To reach full Year 2 budget</i>

**YEAR 3 BUDGET SUMMARY: UNMET NEED**

Component	Amount (\$)	Type	Notes
OIFR cash support*	\$25,000	Contribution	Already committed
Total Year 2 program cost	\$127,179.25 (3% COLA)	—	Complete funding package
<i>External or additional funding</i>	<i>\$102,180</i>	<i>Required</i>	<i>To reach full Year 3 budget</i>

\*OIFD hopes to be able to contribute more than \$25k in years 2 and 3 (2027-2028), dependent upon a planned 2027 levy.

**YEAR 2 DETAIL (JAN '27-DEC '27) PROGRAM BUDGET**

Category	Description	Estimated Cost
Contract/On-Call	Program Pilot Lead (RN or other medical professional)	\$65,000
EMT MIH Hourly	6–12 hrs/week @ ~\$28/hour	\$17,475

<b>Training – EMT and/or other staff</b>	Credentialing, continuing education, and MIH-specific training	<b>\$5,000</b>
<b>Program Software</b>	MIH data platform, maintenance and support	<b>\$14,000</b>
<b>Medical Supplies &amp; Consumables</b>	Field kits, PPE, and replenishable materials	<b>\$8,000</b>
<b>Training Materials</b>	Manuals, educational resources, and certification materials	<b>\$2,000</b>
<b>Administration &amp; Reporting</b>	Program coordination, data management, and evaluation support	<b>\$7,000</b>
<b>Contingency (≈5%)</b>	Unanticipated expenses or cost adjustments	<b>\$5,000</b>
<b>Total Budget</b>	—	<b>\$123,475</b>

## Funding & Reimbursement Considerations

### Payer Reimbursement

There are no Mobile Integrated Health, Community Paramedicine or other related programs in Washington State who are significantly funding their programs by insurer reimbursement. Currently no payers in Washington State have contracted relationships with any such program.

The most likely pathway to reimbursing some MIH services is pursuing a Home Health Shortage Area Designation through Island Hospital, and contracting with them to deliver services that may qualify for reimbursement under Medicare (Chronic Care Management, Transitional Care Management) and certain Medicaid managed care contracts. In this arrangement, the clinic would bill Medicare/Medicaid for Transitional or Chronic Care Management services, the OIFR RN would deliver the service, and OIFR would receive some reimbursement through a shared funding agreement. OIFR cannot directly bill for RN services, as fire districts are not licensed clinics.

Additionally, OIFR and OIHCD will monitor state and federal policy developments that may create direct reimbursement pathways for MIH/CARES programs and will pursue opportunities for value-based care partnerships and grant funding. But to be clear, Washington is far behind the curve in developing statewide reimbursement conditions that incentivize payers to buy into this type of program, and there is very little organized movement in the state to build sustainable funding pathways for MIH and related programs.

## Other Funding Sources

OIHCD Community Health Project Manager is seeking philanthropic and grant funding for the project in Year 1 and beyond. The Northsound Accountable Communities of Health (ACH) is a potential source of funding in Year 2 (January 2027), if OIFR becomes an ACH Partner and applies for funding through one of their annual community grants. OIHCD and OIFD will continue to monitor State and Federal grant opportunities to support the program.

## Years 2 and 3 Program Development & Cost Considerations

In 2027 and 2028, program expansion would require increased Program Lead (RN or other medical professional) capacity, representing the primary source of additional costs during those years.

## Program Authority (Per RCW 35.21.930)

Section	Details
<b>Statutory Authority</b>	RCW 35.21.930 – Authorizes fire departments and fire protection districts to establish Community Assistance, Referral, and Education Services (CARES) programs.
<b>Program Purpose under RCW 35.21.930</b>	To identify and assist residents who frequently rely on 911 and emergency services for low-acuity or non-emergent needs.
<b>Authorized Activities</b>	<ul style="list-style-type: none"><li>• Employ or contract with healthcare professionals (e.g., EMTs, paramedics, RNs) under the supervision of the agency’s Medical Program Director.</li><li>• Collaborate with healthcare and social service providers to improve outcomes and reduce unnecessary emergency department utilization.</li><li>• Establish and collect reasonable charges for services if approved by resolution of the Board of Fire Commissioners.</li></ul>
<b>Oversight and Coordination</b>	The MIH program will operate within the scope of RCW 35.21.930, with medical oversight provided by OIFR’s Medical Director, and in close coordination with each patient’s primary care provider.

## Clinical Oversight

Role / Function	Description
<b>Medical Direction</b>	Provided by OIFR’s Medical Director, ensuring clinical oversight, adherence to protocols, and quality assurance for all patient care activities.

<b>Primary Care Coordination</b>	All MIH interventions and care plans are coordinated with each patient’s Primary Care Provider (PCP) to ensure continuity, avoid duplication, and support long-term health outcomes.
<b>Program Lead Nurse (RN, 0.6 FTE)</b>	Serves as the MIH Program Lead Nurse, responsible for daily clinical operations, patient intake and triage, coordination of care, documentation, and data reporting.

## Governance, Oversight & Program Advisory Bodies

Structure / Role	Description
<b>Joint Oversight Committee Composition</b>	<ul style="list-style-type: none"> <li>• 2 Commissioners from Orcas Island Fire &amp; Rescue (OIFR)</li> <li>• 2 Commissioners from Orcas Island Health Care District (OIHCD)</li> <li>• Fire Chief (OIFR)</li> <li>• Superintendent (OIHCD)</li> <li>• Meets <b>quarterly</b> to review program finances, staffing, performance outcomes, and operational adjustments.</li> <li>• Facilitated by OIHCD Community Health Project Manager</li> </ul>
<b>Community Health Stakeholder Advisory Group</b>	<ul style="list-style-type: none"> <li>• Orcas Community Resource Center</li> <li>• San Juan County Senior Services, Orcas</li> <li>• Island Primary Care Orcas</li> <li>• Compass Health</li> <li>• Fire Chief (OIFR)</li> <li>• OIFR MIH Program Staff</li> <li>• Private PCPs</li> <li>• Meets <b>quarterly</b> to review referral flow, communications, shared data collection pathways, and program adjustments to improve care coordination</li> <li>• Facilitated by OIHCD Community Health Project Manager</li> </ul>
<b>Reporting</b>	<ul style="list-style-type: none"> <li>• Quarterly reports to Joint Oversight Committee regarding progress and adjustments to Implementation timeline, spending and program outcomes.</li> <li>• An annual report summarizing program outcomes, spending, and recommendations will be prepared and submitted to both the OIFR and OIHCD Boards for review.</li> </ul>

## Interlocal Agreement

Element	Description
<b>Statutory Authority</b>	The MIH program will operate under a formal <b>Interlocal Agreement (ILA)</b> executed pursuant to <b>RCW 39.34</b> , which authorizes cooperative actions between public agencies.

<b>Filing Requirements</b>	The executed ILA will be <b>filed with the San Juan County Auditor</b> or <b>posted on the websites</b> of the participating agencies in compliance with state law.
<b>Scope &amp; Purpose</b>	The ILA defines the structure and responsibilities for program funding, governance, liability, and termination conditions between OIFR and OIHCD.

### Pilot Evaluation Metrics

<b>Evaluation Category</b>	<b>Performance Metric / Indicator</b>
<b>Program Infrastructure</b>	Approval of key program documents, including staff job descriptions, program policies & practices, consent and release forms
<b>911 Diversion</b>	Number of non-emergent calls redirected to MIH resources instead of EMS transport.
<b>Patient Outcomes</b>	Improvements in chronic disease management, medication adherence, and reduction in hospital readmissions.
<b>Care Coordination</b>	Number and type of referrals made through MIH software to primary care, behavioral health, and social services.
<b>Financial Impact</b>	Estimated healthcare cost savings for patients, OIHCD, and insurers.
<b>Satisfaction</b>	Patient, family, and provider satisfaction surveys regarding MIH services.

### Implementation Timeline (15-Month Plan including Start-up, 8-mos Pilot)

<b>Timeframe</b>	<b>Key Activities &amp; Milestones</b>
<b>Months 1–2 (Nov–Dec 2025): Governance &amp; Program Authorization</b>	<ul style="list-style-type: none"> <li>• Secure OIFR and OIHCD Board approvals.</li> <li>• Draft and execute Interlocal Agreement (RCW 39.34).</li> <li>• Determine which organization will serve as the legal and administrative backbone for the interisland MIH program.</li> <li>• Establish Joint Oversight Committee structure and meeting schedule.</li> <li>• Define the core problems the MIH program will address.</li> <li>• Approve recruitment plan and finalize job descriptions for key roles (contracted Program Development Consultant, EMTs, administrative support, project management support role from OIHCD).</li> </ul>

**Months 3–4 (Jan–Feb 2026): Recruitment & Onboarding**

- Onboard Program Development Consultant.
- Confirm medical oversight framework with Medical Director.
- Convene community Health Stakeholder Advisory Group to discuss pilot program purpose, scope & communication/referral pathways and get feedback.

**Months 5–6 (Mar–Apr 2026): Program Design & Infrastructure Development (with support from Program Development Consultant)**

- Define eligibility, enrollment, and disenrollment criteria.
- Develop detailed intake and referral workflows.
- Evaluate EHR and MIH software options; select and configure shared documentation platform ([HealthCall](#), [AthenaHealth](#), [Julota](#)).
- Draft policies, procedures, and HIPAA-compliant data storage protocols.
- Define services to be offered at launch and related performance metrics.
- Begin drafting patient consent and release of records forms.
- Establish communication and escalation protocols with PCPs and partners.
- Begin EMT training for MIH role (intake, care coordination, and resource navigation).

**Months 7–8 (May–Jun 2026): Process Finalization & Pilot Launch**

- Finalize MIH software configuration and deploy a shared documentation system.
- Build templates for care plans, visit documentation, and reporting dashboards.
- Create post-visit satisfaction survey tools and follow-up scripts.
- Develop and document enrollment workflow with checklists and scripting.
- Conduct test runs of documentation, referral, and communication systems.
- Finalize MIH staff training (clinical, operational, documentation).
- Finalize all forms, SOPs, and clinical protocols.
- Train all OIFR field staff on how to identify appropriate MIH referrals, and how to refer patients into the program.
- Launch MIH pilot with initial patient visits.
- Begin active data collection, reporting, and QA/QI review.

**Months 9–10 (Jul–Aug 2026): Initial Operations**

- Conduct first quarterly Oversight Committee review post-launch.
- Convene Community Health Stakeholder Advisory Group to review initial program flow, collect feedback and adjust communication and referral practices.

- Adjust referral and communication workflows as needed.
- Refine KPI dashboard for ongoing performance monitoring.

**Months 11–12 (Sep–Oct 2026): Program Evaluation & Optimization (Mid-Year Review)**

- Review early program data, patient outcomes, and satisfaction findings.
- Conduct staff and stakeholder (outreach to Community Health Stakeholder Advisory Group) feedback sessions.
- Document lessons learned and prepare mid-pilot summary for Oversight Committee.
- Assess sustainability options and prepare recommendations for future funding or expansion; Produce Year 2 Project Prospective and funding request for OIHCD and OIFD Boards.

**Months 13–14 (Nov–Dec 2026): Expansion & Sustainability Planning**

- Compile cumulative evaluation data across objectives (911 diversion, outcomes, satisfaction, cost impact).
- Continue data-driven quality improvement and reporting.
- Conduct final Oversight Committee and Community Health Stakeholder Advisory Group review.
- Outline next steps for long-term sustainability and county-wide collaboration.

**Month 15 (Jan 2027): Final Evaluation & Recommendations**

- Produce comprehensive Year 1 Evaluation Report summarizing outcomes, performance metrics, and lessons learned.
- Present recommendations for program continuation and modification.

Appendix A: FINEST Framework Planning Outline

FINEST Framework Category	Action 	Progress
FOUNDATION	Determine which organization will serve as legal and administrative backbone for the interisland MIH program	
FOUNDATION	Define core problem(s) MIH is solving	
FOUNDATION	Define eligibility criteria for program enrollment	
FOUNDATION	Define what it means to "enroll" a patient	
FOUNDATION	Define criteria for "disenrollment"	
INFRASTRUCTURE	Identify method for initial referrals, grow for program need	
INFRASTRUCTURE	Recommend building of web-based referral form for hospitals, clinics, or community agencies and stakeholders	
INFRASTRUCTURE	Determine how patients will reach the MIH team(s) Example: direct phone line, routed from dispatch, text	
INFRASTRUCTURE	Evaluate electronic health record (eHR) cost-benefit and capabilities Establish a shared platform for MIH program implementation and documentation.	
INFRASTRUCTURE	Build templates for specific patient populations or enrollment categories	
INFRASTRUCTURE	Build a system for collecting Key Performance Indicators (KPI) metrics and create a dashboard for real-time reporting.	
INFRASTRUCTURE	Define weekly, monthly, annual reporting workflows for internal and external stakeholders	
INFRASTRUCTURE	Determine approach for leveraging HIPAA-compliant system and develop best practices, policies for storing records	
NAVIGATION	Identify core team: EMTs, paramedics, volunteer vs non-volunteer. Incorporate RN, NP/PA, BH clinician (as feasible via partnerships or telehealth)	
NAVIGATION	Define team roles and staffing strategy, Develop Job Descriptions for each MIH position.	
NAVIGATION	Identify needs and volume related administrative activities	
NAVIGATION	Draft and finalize Patient Consent Form and Release of Records Form	
NAVIGATION	Identify, draft, and finalize policies, procedures, and protocols (SOPs).	
NAVIGATION	Ensure adherence to key compliance items	
ENGAGEMENT	Create step-by-step Enrollment and Intake workflow. Establish as SOP, with accompanying checklists, forms, templates etc	
ENGAGEMENT	Identify key scripting for initial patient contact, effective triage, eligibility screening, scheduling, expectations management, and patient enrollment	
SERVICES	Define services which should be offered at launch	
SERVICES	Establish medical direction; how real-time clinical escalation will occur	
SERVICES	Including didactic, clinical, board certification, and skills assessments	
SERVICES	Identify, curate, and organize MIH training resources for initial and ongoing	

	education.	
SERVICES	Establish clinical and operational protocols or procedures aligned with clinical interventions, program goals, and/or care plans. Establish workflow for creating and sharing care plans and/or appropriate care plan progress	
SERVICES	Determine goals for response time	
TECHNOLOGY	Determine method and frequency of patient communication	
TECHNOLOGY	Determine methods, frequency for internal and team communications	
TECHNOLOGY	Determine methods, frequency for routine stakeholder/partner updates; Determine scenarios, triggers, processes for nonroutine updates	
TECHNOLOGY	Develop a process for data collection and sharing; align with stakeholder and sustainability priorities if feasible	
TECHNOLOGY	Develop post-visit satisfaction tool or follow-up call script. Determine timeline and processes for distribution, collection, reporting	
TECHNOLOGY	Incorporate MIH service elements into existing QA/QI processes	
TECHNOLOGY	Develop processes for effective utilization management	