

# IMHA Charts Course for Mobile Healthcare

As mobile healthcare becomes increasingly important worldwide, one organization is leading the way through this relatively new territory.

BY DAN HARVEY

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**F**ifteen years ago, when the subject of mobile healthcare was introduced, people generally thought about health screening—particularly mobile mammography—or blood drives.

Since then, the concept of mobile health has grown to include much more. Mobile units now provide an array of healthcare services, including primary care, acute care, HIV/AIDS education and testing, dental, eye care, immunization, and prostate cancer screening. The populations they serve are equally as diverse, from seniors to children and adolescents, from farm workers to the corporate workforce, and from homeless to the general public, to name a few.

However, as the complexity of services has increased, so has the complexity of issues facing mobile healthcare owners and operators. The International Mobile Health Association (IMHA) was created to help these providers tackle such issues.

### The IMHA

The IMHA is a relatively new organization. In November 2001, the IMHA held its First Annual International Conference on Mobile Health. In November 2002, it held its second. In between the two events, the association itself was born.

The IMHA—and its conferences—was designed as a vehicle for sharing information about successful mobile health strategies. Issues it addresses include needs assessment, funding, equipment, staffing, maintenance, and community relations. Also, as its name implies, it seeks to increase global awareness about the importance of mobile health programs.

Shirley L. Pinette, MS, RT(R)(M)(QM), president of the IMHA, says the association filled a perceived need: Many people want to become involved with mobile health but don't know how to proceed, and those already involved often need help with the unique problems and situations they encounter. "Before the first conference, there had been much talk among many mobile health owners and operators that there wasn't an association or conference that could allow us to network and learn from others," she says. "At the end of the meeting, many attendees felt that such an association would be invaluable."

Mobile health has become such an amorphous subject that such an association seemed both necessary and inevitable. It covers a lot of territory, so to speak. There are many different types of programs and various elements to consider. Pinette explains that some mobile units are owned and operated, and others are contracted out. Some are non-profit, and some are for profit. Some are staffed by technologists, such as mobile mammography vans; others, such as primary care providers, are staffed by physicians and nurse practitioners. "With mobile health programs, there is no such thing as a norm," she says.

Development of the organization was swift. Immediately after the first meeting, an executive director was selected, officers were appointed, and bylaws were written. One of the first tasks was drafting a mission statement, which now reads: "The association seeks to increase global awareness of mobile health programs as an innovative and efficient means for increasing access to quality healthcare, community wellness initiatives, and preventative care services for underserved populations. It is our goal to provide continuing education, networking, and communication tools that offer inspiring and thought-provoking forums for sharing expertise and building relationships with professionals engaged in mobile health worldwide."

With her experience and dedication, Pinette was the logical choice for president. She had also been active in organizing the first conference. "People put my face with the association,"

#### **IMHA Mission Statement:**

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she says, "and they know I'm involved with another national healthcare certification board."

Pinette is manager of breast imaging/outpatient radiology at Yale-New Haven Hospital in Connecticut, a 15-year-old mobile mammography program. Its 35-foot unit visits local businesses, senior centers, visiting nurse associations, and shopping malls to perform a full schedule of screening mammograms on women aged 40 and older. The van has performed more than 75,000 mammograms. It is accredited by the American College of Radiology and has passed seven annual Mammography Quality Standards Act inspections.

Pinette was recently reelected to serve as IMHA president for this year. Though she says her role is evolving, she describes herself as a steering person, guiding the organization into the future. At first, her primary function was to help develop the association. Now she wants to take it to the next level. She is especially concerned with broadening its interna-

tional focus. "Our Web site ([www.intlmobilehealthassn.org](http://www.intlmobilehealthassn.org)) is a valuable tool for healthcare providers worldwide to communicate with each other and expand their knowledge about the benefits and implementation of a mobile health program," says Pinette.

### Primary Concern: Access

Of all the topics addressed, the primary concern of the IMHA and its members is access—an issue deemed especially crucial in today's healthcare environment, where problems involving healthcare accessibility are reaching crisis proportions. As such, mobile programs are increasing, since they offer quality, cost-effective healthcare to the disenfranchised. "The goal is not to replace existing ongoing healthcare. We see ourselves as an access point," says Cathy K. Recht, RN, vice president of community relations for the mobile program at the UMass Memorial Health Care in Worcester, and a presenter at the 2002 IMHA conference.

In the context of mobile health, access—or lack of—takes on several meanings. Patient access, as both Pinette and Recht indicate, can involve financial considerations, geographical distances, and social or psychological factors.

For many patients, the financial aspect is particularly problematic. According to the U.S. Census Bureau, 44 million Americans are "locked out" of the healthcare system because they lack health insurance. The IMHA wants to make sure these people are served. Access also means going into areas where healthcare is not available. "There are rural communities in the United States and other parts of the world where there are no nearby hospitals or physician offices," says Pinette. "Mobile health services go into these communities and provide access to medical care."

She also notes that some people deny themselves healthcare because they are intimidated by driving into large cities. For these patients, mobile health units can provide much easier and more convenient access. "In Connecticut, we have a tremendous number of healthcare facilities in a small area," says Pinette. "However, many people, older people especially, don't want to drive into the cities. Many prefer to receive healthcare in their own area where they feel more comfortable."

Recht is aware of other social and psychological issues involved. "People lack access because of other barriers," she says. "In Worcester, we have many immigrants in our community who don't know how to use the healthcare system. So when you go into their neighborhood, they tend to develop trust."

When a trusting relationship is formed, she says, a bridge from the mobile program to the traditional healthcare system is created. Once that connection is established, Recht says, ongoing care becomes the norm.

The same access issues are present overseas, which is why the association has a strong international focus. "There are many



parts of the world where delivering healthcare to people is difficult," says Pinette. "In some countries, there are 500 miles between hospitals. In many global situations, mobile health is the key to access and quality healthcare."

### Fundamental Concerns

Beyond those larger issues, the association is concerned with informing members about specific nuts-and-bolts issues of operating a mobile health program—particularly public relations, finances, and maintenance. Perhaps the biggest concern for mobile health providers is money. "Financial concerns are complex and many," says Recht.

In her conference presentation, Recht discussed different funding strategies that can help sustain a mobile health program (eg, funding diversification, securing grants, grant-writing tips, and corporate and individual support). "Mobile programs are expensive to run, so there has to be a specific plan for how money will be raised because either people don't have insurance or the public payors don't pay enough to cover the costs," she says.

Insurance and reimbursement are big headaches. Generally, mobile health entails higher cost than a traditional facility; yet, they receive the same insurance reimbursements as traditional facilities. Fortunately, more third-party payors are starting to accept mobile programs. This acceptance didn't—and in many cases, still doesn't—come easily. But that attitude is starting to change. Still, much depends on specific situations, says Pinette. "I can only speak for my program," she says. "We do get reimbursed by third-party payors; however, sometimes it takes some time to explain to them that we're not some fly-by-night operation but a certified organization staffed with qualified people. Sometimes much legwork must be done up front to make certain that you are going to be reimbursed."

One of the problems, says Gloria A. WilderBrathwaite, MD, MPH, director of mobile health programs for the Children's National Medical Center, Washington, D.C., is that most payors don't know how to reimburse for mobile health or they reimburse it at the level of primary care, which is already low. That makes it hard to sustain a program. "Mobile health is costly," she says. "The units are expensive, and cost of delivery of service is expensive. On average, the cost of a new vehicle can run from \$250,000 to \$400,000 depending on the level of technology utilized

on board. But when you analyze that cost over the lives of the patients and determine how much you are saving in the long run, then mobile healthcare becomes inexpensive. That is the message that we have been trying to get across to insurers."

Another nuts-and-bolts issue the association addresses involves, literally, nuts and bolts: equipment and vehicle maintenance. Mobile unit staffers have to be concerned with details such as gas mileage, oil changes, and when and how to get repair work done. "My technologists have to worry about the things that a technologist in a facility doesn't have to worry about, such as changing the oil," reveals Pinette.

Staffers also have to bother with the cost of repairs and new equipment. Wear and tear from travel can be considerable. After all, the vans cover great distances, some traversing rough terrain. Also, medical equipment maintenance has to be performed more frequently. This adds to the costs, but it is essential. Technologists don't want to experience malfunctions and breakdowns while on the road.

### Mobile Units

Like so much else about mobile health programs, a van comes in different shapes and sizes. In fact, Recht doesn't prefer the term "van." She views a unit as a mobile office. "It is built from the chassis up to be like a medical office," she says about her program's unit. "We have two care rooms and a waiting room, which also includes laboratory space and registration. We have a medical exam room and a dental room."

WilderBrathwaite's program has two vehicles on the road. Each is approximately 38 feet long, has three exam rooms, an electronic patient record system, and all of the equipment that you would find in any doctor's office. Onboard technology in other units can also include electronic tools to perform administrative functions such as scheduling, reporting, and billing. Almost all units now include laptop computers that maintain connection to the home base.

Services provided depend on the particular program, and they run the gamut from primary care and acute care to radiologic screening. Some specifically target pediatric care. "We handle children who are uninsured or who don't have access to healthcare, either because of homelessness or transportation issues," says WilderBrathwaite.

Recht's program has the distinction of being the first vehicle of the international launch of the Ronald McDonald Care Mobile program. "They wanted another way to reach out for healthcare to children and their families, and they felt that one of the most effective ways to do that was through a mobile program," she says.

### Mobile Radiology

Mobile radiology services are no longer restricted to mammography. Currently, units

are on the road offering cardiac and vascular sonography, nuclear medicine, MRI, PET, and CT. "Mobile health is going into every avenue of medicine and radiology that you can imagine," says Pinette.

One of the advantages that mobility provides, she points out, is that facilities that can't afford new radiology technology can contract for mobile services. "Not every place can afford an MRI unit," she says. "Maybe there's a small hospital that would like to be able to provide MRI services but can't afford the equipment, or they don't think they will receive enough cases to warrant the expense. Mobile services are becoming valuable to those locations."

In fact, such contracting is becoming more common and is increasingly deemed viable. "For instance, there is a place near me that would like to provide bone densitometry to their patients," says Pinette, "so they've contracted with a hospital to have a densitometry van come by once a month. Now they can provide that service to their patients on a regular basis."

In the future, teleradiology will become a fixture on more mobile health units. Many unit operators and owners already transmit images and information via telemedicine and teleradiology, according to Pinette. WilderBrathwaite says that telemedicine equipment was recently installed onto her program's mobile units. "It is just basic right now," she says. "We haven't gone live in the field yet, but we've put it on board."

### Validation

The value of mobile healthcare has certainly been demonstrated, especially in providing patient access. However, it is not firmly entrenched in the healthcare system just yet. "There are still some programs that are struggling," says Pinette.

The IMHA, and individuals such as Pinette, WilderBrathwaite, and Recht, are working to see the concept become completely integrated into traditional healthcare.

Already, the U.S. government understands the value of mobile health—especially when it is coupled with telemedicine. "The government sees mobile units as a way of getting healthcare into an area in a rapid manner," Pinette says. "No event validated its importance more than the events of September 11. Two mobile health coaches from Jamaica Hospital pulled into New York City immediately after the attack [on the World Trade Center], before the on-site hospital tents were set up. Mobile health units will play a vital role in the development of future Homeland Defense healthcare initiatives that deal with bioterrorism and emergency preparedness on a community level."



— Dan Harvey is a staff writer at *Radiology Today*.