FIRST EDITION ACCREDITATION STANDARDS FOR MOBILE INTEGRATED HEALTHCARE PROGRAMS

Commission on Accreditation of Medical Transport Systems

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MISSION STATEMENT

CAMTS is a peer review organization dedicated to improving patient care and safety by providing a dynamic accreditation process through the development of standards, education, and services that support our vision.

VISION STATEMENT

All patients receive appropriate and safe out-of-hospital care by qualified professionals.

CAMTS VALUES

FAIR
ETHICAL
CONSISTENT
ACCOUNTABLE
PATIENT AND SAFETY FOCUSED

SERVICE ORGANIZATION EXPECTATIONS

Honest Self-Assessment
Ethical Business Practices
Patient and Safety Focused
Continuous Quality Improvement
Transparency in the Accreditation Process

PREAMBLE

The Commission on Accreditation of Medical Transport Systems Accreditation Standards (CAMTS) reflect ongoing changes in healthcare, the medical transport profession and now, Mobile Integrated Health Care (MIH). Commitment to patient care and safety form the foundation of these voluntary standards. This first edition of the Mobile Integrated Healthcare Program Accreditation Standards has been vetted by the MIH profession through the American National Standards Institute (ANSI) standards-setting process in subsequent drafts over the past two years.

MIH is a relatively new and expanding field of health care focused on providing primary and preventive care to underserved populations. The goals include increasing access to care; improving health and well-being; and reducing hospital admissions, readmissions, emergency room visits, and costs. Care providers can come from any area of health care, but most MIH services use paramedics in expanded roles caring for clients in nonemergency situations in their homes or other locations. MIH varies and can be as simple as checking on patients with chronic illnesses to at home testing and interventions that may include telemedicine. This out-of-hospital care has become even more prevalent due to the pandemic and the need to limit crowded emergency departments and lower the risk of exposure to a coronavirus disease.

The Commission on Accreditation of Medical Transport Systems (CAMTS) is proud to announce the release of the first national accreditation standards for MIH programs. Some MIH programs operate independently, and others may be part of a transport service or health care organization. The standards reflect months of work with input from some of the national leaders in existing MIH programs. Although CAMTS is primarily an accreditation for medical transport, this is another aspect of out-of-hospital care that involves the same disciplines. Also, the infrastructure of CAMTS is well-established to create and approve standards with over 30 years of experience.

The Commission recognizes and accepts its responsibility to review and evaluate the relevance and applicability of its standards. Accreditation Standards serve as the resource for site survey visits and as criteria for accreditation decisions by the Commission. Accreditation Standards are also used as a blueprint for organizational planning and benchmarks on a worldwide basis. These standards are written by and for those involved in medical transport and out-of-hospital care. Therefore, these standards belong to the entire medical transport and out-of-hospital care community. As standards are dynamic and not static, CAMTS values its constituents' comments and suggestions for future changes. To submit comments or to review any of the CAMTS Standards at no charge, visit our website at CAMTS.org.

ACCREDITATION FOR ACCREDITATION

The Commission on Accreditation of Medical Transport Systems is proud to be an Accredited American National Standards Institute (ANSI) Accredited Standards Developer (ASD) since 2017. CAMTS is one of less than 250 ANSI Accredited Standards Developers which includes organizations such as the American Dental Association (ADA), Underwriter Laboratories (UL) and the National Fire Protection Association (NFPA).

These Standards have been updated using the ANSI Essential Requirements: Due process requirements for American National Standards. We want to thank all those that submitted comments and we especially want to thank those on the CAMTS MIH Standards/Consensus Committee that worked on this First Edition of the CAMTS Mobile Integrated Healthcare Program Accreditation Standards.

The American National Standards Institute (ANSI) is a private, non-profit organization that administers and coordinates the United States voluntary standards and conformity assessment system. Founded in 1918, the Institute works in close collaboration with stakeholders from industry and government to identify and develop standards and conformance-based solutions to national and global priorities. The hallmarks of the ANSI process ensure the development of standards are done in a manner that is equitable, accessible and responsive:

- Participation is open to all interested stakeholders
- Balance of interests is sought
- Consensus is reached, without dominance by any party
- The Standards are open for public review and comment
- All comments receive a written response
- All attempts are made to resolve objections before a consensus vote
- There is an appeals process to address procedural concerns

ANSI
American National Standards Institute

MEMBER

ANSI
ANSI Accredited Certification Program

The First Edition CAMTS Mobile Integrated Healthcare Program Accreditation Standards are for CAMTS Accreditation only and follow the ANSI Essential Elements process. They are not approved as ANSI Standards at this time.

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FIRST EDITION TABLE OF CONTENTS

MIH 04.00.00 Vehicle Operations

Addendums

FIRST EDITION ACCREDITATION STANDARDS
for
MOBILE INTEGRATED HEALTHCARE PROGRAMS
of the
Commission on Accreditation of Medical Transport Systems

— PREFACE —

The Mobile Integrated Healthcare (MIH) program's mission statement and scope of care sets the basic foundation for the policies, procedures, and programs to ensure quality patient care and safety. Recognizing the uniqueness of each MIH service, the Commission will apply the standards in the context of the program mission statement, scope of care and available resources. Accreditation is based on the principle of substantial compliance – demonstration of overall quality of service consistent with the essential elements of the accreditation standards in the professional judgment and discretion of the Board. The accredited service will demonstrate a steady balance in all dynamic components which comprise their specific program.

The standards are as appropriate to the state of residence and the specific regulator of that state as referenced by the term "Authority Having Jurisdiction" (AHJ). CAMTS Accreditation Standards, as a measure of quality, are part of a voluntary process and frequently exceed the AHJ's regulations.

The term "patient" is used throughout the standards. Programs may not see all participants in their Mobile Integrated Healthcare Program as "patients" and may refer to them as participants, members, or other terms. For purposes of the Standards, these terms are interchangeable.

MIH 01.00.00 – MANAGEMENT AND STAFFING

MIH 01.01.00 MISSION STATEMENT AND SCOPE OF CARE

MIH 01.01.01 There is a Mission Statement written in the present tense that describes the purpose of the service, types of services provided and its constituents. The Mission Statement reflects the values upon which the service was founded.

MIH 01.01.02 There is a written scope of service that describes the types of patients accepted (Scope of Care), services provided, and exceptions. Scope of Service includes range of services, procedures performed, response time, staffing configuration(s)**,** and any exceptions to types of requests that are accepted. In addition, the scope of services should be defined considering:

1. Improving patient outcomes
2. Reducing individual and health care system costs
3. Reducing hospital admissions and readmissions
4. Improving patient access to care
5. Improving health care system capacity
6. Improving health equity
7. Meeting community needs and expectations
8. Addressing resource availability
9. Building a healthy community
10. Disease prevention and focus on health
11. Assuring financial stability of the program
12. Helping patients identify barriers and meet their goals of care
13. Deliver 5R Model: Right care, Right place, Right timeframe, Right Quality, Right cost
14. A statement of support from Medical Direction
15. Establishment of program benchmarks that ensure program evaluation and evidence-based/data driven decisions

The Scope of Care is commensurate with the qualifications and level of initial and ongoing education required for medical practitioners. The Scope of Care should address, as applicable to the program, patient populations served, age groups, and their definition. The Scope of Care may include discrete tasks and interventions or may include delivery of advanced clinical care services beyond the scope of traditional paramedicine.

Note: The term "patient" is used throughout the standards. Programs may not see all participants in their Mobile Integrated Healthcare Program as "patients" and may refer to them as participants, members, or other terms. For purposes of the Standards, these terms are interchangeable.

MIH 01.01.03 There is a comprehensive inventory that identifies the availability and distribution of current capabilities and resources for a variety of partners and organizations throughout the community.

Examples of evidence to meet compliance:
The Mission Statement describes what you do in a clear and concise manner. The vision and mission are strategic statements developed by and unique to each organization. Values statements are separate but key underpinnings of these statements. The community-wide resource assessment documents the resources available in the local community to help meet the clinical, behavioral, and social needs of patients that may be enrolled in the community MIH program.

MIH 01.02.00 FINANCIAL COMMITMENT

MIH 01.02.01 There must be evidence of financial commitment to the program by the administrative structure and through financial resources that contribute to excellence in patient care and safety.

Examples of evidence to meet compliance:
Vehicles or care sites are well kept – equipment and supplies are well maintained, accessible, and adequate for the patient population(s)/volume. There are plans for replacement of vehicles and equipment as needed. Physical administrative surroundings are well maintained. There are adequate management and staff personnel for patient volume. Education appropriate to the scope of care and to all aspects of the organization (coordinators, practitioners, etc.) is provided.

MIH 01.02.02 Insurance – The community medical service must have and maintain insurance against loss or damage of the kinds customarily insured against and in such types and amounts as are customarily carried under similar circumstances by similar businesses. The insurers must be financially sound and reputable, and they must be qualified to do business in the state(s) in which the service is located.

The types of insurance must include but are not limited to the following:

1. Auto insurance (for ground vehicles owned by the service) – $1 million (U.S. dollars) and includes accidental death and disability

2. General Liability– $1 million (U.S. dollars)

3. Worker's compensation or employer's liability – per state or equivalent government guidelines

4. Group life insurance or accidental death and disability – whether paid for by the employer or employee. A minimal coverage of one times the annual salary is encouraged.

Insurance for ransomware or internet theft is encouraged.

MIH 01.03.00 MARKETING AND EDUCATION FOR THE PUBLIC

MIH 01.03.01 There is a stakeholder's users' group that provides guidance and consultation on operations and policies relative to the communities served. This group may include (and not be limited to):

1. Clinical providers
2. Social Services
3. Public Health
4. Public Safety – Police, Fire, media
5. Pharmacy
6. Mental Health (including substance abuse facilities/councilors)
7. Housing organizations/agencies (including homeless shelters)
8. Suppliers (durable medical equipment, gases, medications, etc.)
9. Community leaders
10. Clergy
11. Emergency Management
12. Interpreter Services (foreign language, sign language, etc.)
13. Patients and/or patient advocates
14. Hospitals and healthcare systems
15. Third party payers (State Medicaid, insurance companies, etc.)
16. Local/State government

17. Healthcare coalition

18. Institutions of Higher Education

MIH 01.03.02 There is a professional and community education program and/or printed information with the target audience to be defined by the community medical service.

1. Clear identification of the sponsoring agency(s) with appropriate contact information

2. Website information and printed materials are accurate and consistent with program documents, practice, and capabilities, including the program's mission and vision statements

3. Evidence of state licensure (or authority having jurisdiction (AHJ)) is provided for each vehicle and care site as appropriate to state or local guidelines

4. State or local license (or AHJ) for each vehicle and care site are accessible to the public

5. Hours of operation, phone number, and access procedure are accessible to the public

6. Capabilities of medical practitioners - including current scope of care, a list of types of patients who are accepted based on personnel training, and configuration and equipment capabilities - are included

7. Coverage area for the service is specified

8. Access requirements to the service are outlined

9. Patients considered appropriate for service are specified

Examples of evidence to meet compliance:
Marketing materials are up to date, consistent with mission and scope, depict actual types of services and service area, and do not exaggerate the scope of care or capabilities.

MIH 01.03.03 There is an annual report provided to the members of the stakeholder's users' group that outlines the number of patients served, number of visits, cost of the program, estimated patient and health systems financial cost reduction, patient outcomes, major program changes, and overall impact on improving the community served.

MIH 01.04.00 ETHICAL BUSINESS PRACTICES

MIH 01.04.01 The service develops and demonstrates use of a written code of ethical conduct in all areas of business that exhibits ethical practices in business, marketing, and professional conduct.

1. The code of conduct guides the service when confronted with potential compliance or ethical issues

2. The code of conduct outlines the service's standards for ethical behavior, as well as contact information and reporting protocols if a standard has been violated

3. The code of conduct outlines ethical billing practices

4. Upon request, for elective and/or non-emergent care or services, the program provides the patient, patient family member or third-party payor with a timely written, honest best estimate of the total cost of services

5. There is a policy that addresses privacy rights regarding photography and the use of photos or other media that includes prohibiting photos placed in social media that would compromise HIPAA requirements without a patient's written permission

6. There is a policy or plan that addresses how the program will/should utilize social media platforms

Examples of evidence to meet compliance:
Policies may address such issues as proper/improper behavior toward other programs' marketing materials, honesty in reporting data, personal cell phone use, use of social media sites, how ethical issues are addressed, conflicts of interest, phone etiquette, acceptable and unacceptable behaviors on the worksite, acceptance of gifts from patients/vendors, etc.

MIH 01.04.02 The Board of Directors, administrative and management staff are encouraged to complete an annual conflict-of-interest statement or form, disclosing any actual or potential conflicts.

MIH 01.04.03 Ethical business practices must be maintained in policy and practice and include specific guidelines for service requests that are not performed directly by the CAMTS-accredited service or service seeking accreditation as follows:

1. Referring service requests – Referring is defined as transferring the service request to another program or service. There is no further involvement on the part of the original services, and there is no monetary exchange for the referral.

2. Subcontracted service requests – Subcontracted is defined as the occasion when another service is used to supply a portion of the care, such as testing, mental health, physical therapy, or the medical team, if the service's medical team is not available or is not appropriate

3. Outsourcing service requests – Outsourcing is defined as transferring a request to another service but retaining control of the coordination throughout the patient care (which may include testing, mental health, physical therapy, etc.). The service may add a fee for coordinating the care, but full disclosure of the name of both the medical provider and the medical care provider employer must be made to the patient, his/her advocate, and the payer source(s).

4. Brokering service requests – Brokering is defined as arranging for services and collecting a fee but not actually performing any patient care or taking any patient care responsibilities. This is not an acceptable practice of an accredited service. If the accredited service or service seeking accreditation cannot fulfill a request for services, the service may elect to subcontract or refer the request.

5. Communications if unable to provide service – The program will notify the requesting/referring agency, at the earliest possible time, as defined by the agency, when it discovers services cannot be completed. If the request for service is referred, subcontracted, or outsourced the requesting/referring agency will be notified of the name and contact information of the program providing service.

MIH 01.04.04 The community medical service will know the capabilities and resources of area receiving facilities and will connect patient to transport options, when necessary, to appropriate facilities within the service region based on patient preference, medical protocols, direct referral, approved EMS plan, or services available when no direction is provided.

1. Contractual relationships with public services or health care agencies do not reflect implied referrals

2. Subscription services do not reflect implied referrals that could negatively impact expeditious transport of patients to the most appropriate facility

Examples of evidence to meet compliance:
Contracts do not exceed current market value for goods and/or services or severely discount current market value with the intent to influence requests or referral patterns.

MIH 01.04.05 All patient care resources necessary to the program's mission, including personnel and equipment, must be readily available and must be operational prior to initiating a patient encounter.

MIH 01.05.00 COMPLIANCE

There is a corporate compliance officer or designated person responsible for ensuring that the service is following external laws and regulations, payer requirements, and internal policies and procedures.

MIH 01.05.01 Compliance issues may include but are not limited to:

1. Health Insurance Portability and Accountability Act (HIPAA)*

    a. If a program is using a form of telemedicine/telehealth, there are policies and procedures that outline how patient privacy issues are protected.

2. Federal civil statutes (False Claim Act) *

3. Balanced Budget Act of 1997*

4. Office of Inspector General (OIG) Compliance Program Guidance*
5. OIG annual work plans *
6. Anti-kickback and Stark laws *
7. Emergency Medical Treatment and Active Labor Act (EMTALA)*
8. Red Flag Rules (Identity Theft Prevention Program) *
9. Federal sentencing guidelines
10. Or applicable state or federal regulations

** (See References)*

MIH 01.05.02 The compliance program includes:

1. Written policies and procedures
2. Designation of a compliance officer or assignment of responsibility to a specific individual or individuals
3. Effective training and education for staff that documents both initial and continuing competency
4. A process that allows and encourages staff to report competency concerns or accidental infractions without fear of retaliation.
5. Effective lines of communication
6. Enforced standards based on published progressive disciplinary guidelines
7. Auditing and monitoring
8. Procedures for responding to detected offenses and taking corrective action

MIH 01.05.03 The program provides timely reporting on requested data to the state(s), or other agencies, in which it responds.

MIH 01.05.04 When appropriate, the program actively participates as an integrated part of the state(s) EMS system in which it responds.

MIH 01.05.05 The program integrates with external regional healthcare stakeholders to assess the overall program effectiveness. A formal assessment and recommendation report is completed at least every two years.

Examples of evidence to meet compliance:
Staff is knowledgeable about current compliance issues.

MIH 01.06.00 MANAGEMENT/POLICIES

MIH 01.06.01 There is a well-defined line of authority.

1. There is a clear reporting mechanism to upper-level management. An organizational chart defines the chain of command and how the community medical service fits into the governing/sponsoring institution, agency, or corporation.

2. For public or private institutions and agencies that contract with a community medical service, there must be a policy that specifies the lines of authority between the medical management team and the public or private institutions' management team

3. All personnel understand the chain of command

4. Managers are oriented to community medical standards and state regulations or AHJ pertinent to community medical services

5. Managers are trained to recognize real and perceived pressures that may influence unsafe acts by staff

6. The program adheres to state, national and/or local community MIH rules and regulations, including licensure requirements

7. A policy must be in place that documents the employer's progressive disciplinary process and protects employees from capricious actions

8. There is a policy that addresses DNR orders

9. There is a policy that addresses transfer and security of patients' personal property

10. There is a comprehensive directory of regional patient care and service resources

11. Management:

    a. Demonstrates strategic planning that aligns with the mission, values, and vision of the service

    b. Sets written guidelines for press-related issues and marketing activities

c. Sets an Emergency Response Plan that includes a Post Accident/Incident Plan (PAIP) and responses to unexpected occurrences involving practitioners, vehicles, and facilities as appropriate to the base of operations

Examples of evidence to meet compliance:
Business plans demonstrate a needs and risk assessment when expanding the service or adding sites, and those plans include staffing, training, and management restructuring for added responsibilities.

Examples of evidence to exceed compliance:
Management is educated to Just Culture and applies Just Culture principles throughout the organization.

MIH 01.06.02 Employment Policies

1. A policy addresses pre-hire background checks that include, at a minimum, criminal background, license verification, and previous employer

2. A policy addresses annual driving record checks and license verifications

3. A policy requires staff to self-report any investigation, arrests, or convictions

4. A policy addresses pre-hire (whether or not it is required) drug screening

5. A policy addresses criteria to require “for cause” drug screening

6. A policy addresses a procedure for employee terminations that ensures protection of program information, physical and electronic data, property, and security. This may include securing the individual’s badge/keys/other access devices, deactivating e-mail accounts/computer sign-ons/remote access/codes, remaining with employee until leaving the premises, inspecting items employee takes with him or her, providing prompt notification of relevant departments/vendors/contractors and patients, procuring property that belongs to the program that the employee may have off site, etc.

MIH 01.06.03 Policy Manual (electronic or hard copy) is available and familiar to all personnel

1. Operational and administrative policies must reflect current practices and be reviewed on a biennial basis as verified by dated manager’s signature on a cover sheet or on respective policies

Examples of evidence to meet compliance:
Policies can be broken out by department/division; however, there must be signatures and revision dates on each specific policy or a cover sheet that represents biennial review with respective review dates and signatures.

MIH 01.06.04 Programs are encouraged to develop a plan for succession and unanticipated extended absence for key positions. The plan should address position vacancies, including when there is no

incumbent to provide transition training, as well as unplanned extended temporary absences, designed to preserve the integrity of the program.

Examples of evidence to meet compliance:
This may include cross-training, identification of successors with support of formal and informal education, mentorship, opportunities to participate in projects/presentations/events in the future role, scenarios/case studies, shadowing, job expansion, mechanisms to preserve and provide access to needed information/documents, contact lists, task lists, detailed instruction on processes that are critical/known only to the position, and periodic review/updating of the plan's references.

MIH 01.07.00 STAFFING

The service must have written operational policies to address each of the areas listed below:

MIH 01.07.01 Scheduling and individual work schedules demonstrate strategies to minimize duty-time fatigue, length of shift, number of shifts per week and day-to-night rotation. (See References for circadian rhythm, Fatigue Risk Management System (FRMS) and other fatigue studies.)

1. Medical practitioners must have the right to call "time out" and be granted a reasonable rest period if the team member (or fellow team member) determines that he or she is unfit or unsafe to continue duty, no matter what the shift length. There must be no adverse personnel action or undue pressure to continue in this circumstance.

2. Management must monitor patient care volumes and service times and the personnel's use of a "time out" policy

3. A written policy addresses the scheduling of on-call shifts, and that policy addresses fatigue by requiring managers to monitor duty times, by tracking QM, and by using fatigue risk management

4. A written policy or risk assessment defines the number and types of medical practitioners to be sent on each patient visit. The personnel level of certification/license and training should be matched to the needs of each patient.

5. Personnel must have at least 10 hours of rest with no work-related interruptions prior to any scheduled shift of 12 hours or more or prior to any on-call shift of greater than 12 hours that is scheduled to precede or follow a scheduled on-duty 12-hour shift. The intent is to preclude back-to-back shifts with other employment**,** educational requirements or school, or significant fatigue-causing activity prior to a shift.

6. The number of consecutive shifts and day-to-night rotations must be closely monitored by management for practitioners, communication specialists, vehicle operators and maintenance personnel

7. A written policy addresses safety and clinical competency requirements for part-time or full-time staff experiencing a low volume of service responses. The policy should assure all staff

are current and competent to the level of full-time, active staff in safety and the use of clinical equipment.

Examples of evidence to meet compliance:
Management monitors fatigue in terms of staffing patterns, patient outcomes, and incidents or accidents with implementation to include Just Culture.

MIH 01.08.00 PHYSICAL AND PSYCHOLOGICAL/EMOTIONAL WELL-BEING

MIH 01.08.01 Physical and psychological/emotional well-being is promoted through:

1. Wellness programs that promote healthy lifestyles (e.g., balanced diet, weight control, no smoking)

2. Resources to promote psychological and emotional well-being such as suicide prevention training, trained peer support team, and how to access employee assistance programs (strongly encouraged)

3. Evidence of an injury prevention program and ergonomic strategies to reduce employee injuries

4. Protective clothing and dress code pertinent to:

    a. A professional dress code appropriate to the area served

    b. Personnel Protective Equipment (PPE) based on the patient encounter

    c. Safe operations appropriate to the environment and time of year

5. Infection control – dress codes address jewelry, hair, and other personal items of medical personnel that may interfere with patient care. Refer to Occupational Safety and Health Administration (OSHA) standards.

6. Written policies addressing:

    a. Duty status during acute illnesses, fever, cough, etc.

    b. Duty status while taking medications that may impair performance related to safety

    c. Impaired practitioners (actual and/or accused)

Examples of evidence to meet compliance:
Personnel are observed following the program's dress codes and are knowledgeable about policies regarding physical well-being. Policies are consistent with current national laws and may address

notification to employer requirement, written documentation requirements to continue on duty, and possible alternative duty assignments if team member is restricted from duty.

MIH 01.09.00 MEETINGS AND RECORDS

MIH 01.09.01 Meetings

1. There are formal, periodic staff meetings, for which minutes are kept on file
2. All meeting minutes (Staff, Safety, QM, etc.) include the following:
    a. Date and time of the meeting
    b. Base identification (if multiple bases)
    c. Meeting type (Staff, Safety, QM, etc.)
    d. List of those in attendance by both name and title or function (i.e., Director, Community Health Worker, RN, Paramedic, Community Paramedic, EMT, etc.)
    e. Name of the person presiding
    f. Discussions (versus just agenda/topic headings)
    g. Assignments and responsibilities for open issues
    h. Progress reports on open issues
    i. Clear identification that an issue has been resolved (loop closure)
3. There are defined methods, such as a staff notebook or digital mechanism, for disseminating information between meetings
4. All meeting minutes (Staff, Safety, QM meetings, etc.) are kept on file and maintained for a minimum of three years

Please note that Staff, Safety, QM, UM meetings can be done separately, in combination, or during the same meeting. If combined, the meeting minutes should have sections clearly identified for each.

Examples of evidence to meet compliance:
Meeting minutes indicate attendance and representation by all disciplines. Action items, timelines, and area of responsibility are well documented and demonstrate a flow of information that indicates tracking, trending, and loop closure.

MIH 01.09.02 Records Management ensures that patient care records, meeting minutes, policies, and procedures are stored according to hospital or agency policies, and HIPAA or privacy regulations are

indicative of the individual community medical service's sensitivity to patient confidentiality in accordance with local and national standards.

1. A record of patient care is completed electronically and is used for assessment of system performance and quality of care and serves as a bi-directional exchange of patient contact information with others associated with the patient's medical care. This includes, but may not be limited to, Primary Care providers, case managers, social service agencies, and payers.

    a. A policy outlines minimal requirements based on the community medical service's scope of care

        - Reason for care/services provided
        - History and trending of present illness/injury, physical exam, weight, vital signs, and pain assessments, per patient needs assessment and program's guidelines
        - Diagnosis/impression
        - Allergies
        - Treatments and medications and patient's response to treatments, procedures, and medications, including an inventory of all medications (prescription and non-prescription)
        - Documentation of pertinent imaging and laboratory reports including Point of Care work
        - A care plan, with outcome goals, as outlined by the referring physician/agency or accepted by the program medical direction
        - Assessment of the patient's home environment including home safety (fall risks), health routines, and living habits
        - Documentation of additional referrals to in-home support services, community resources (such as behavioral health and case management), and assistance with coordination of follow-up appointments
        - Documentation if telehealth was performed, with which provider and any orders given
        - Signature of each care provider and clarity about what care was performed by each provider (administering medications and performing procedures) and who actually documented patient information
        - A plan for continuity of the medical care including how records will be documented, stored, and shared, and to whom the report is given

b. A policy outlines what information and instructions will be left with patients. This information should also include contact information for follow-up when needed.

c. A policy outlines approved abbreviations for use in patient care records. To minimize medication errors risks, the use of the Institute of Safe Medication Practice (ISMP) "Do Not Use" Abbreviation List is strongly encouraged.

d. The electronic healthcare record is capable of documenting medication regiments accurately and appropriately

e. A policy outlines the expectations for completion of patient care records in a timely manner (i.e., 90% completed within 24 hours)

f. A stored permanent electronic patient care record is preferred, but scanned hard copies are acceptable. Where possible, the medical record should be part of, and/or made available to the referring hospital or physician medical record system(s).

Examples of evidence to meet compliance:
Patient records are signed and initialed by the practitioners who performed the treatment or procedure. Records are stored in a secure area that is inaccessible to the public, with accessibility limited according to applicable HIPAA guidelines.

MIH 02.00.00 – QUALITY MANAGEMENT
Includes Quality, Utilization and Safety Management

MIH 02.01.00 QUALITY MANAGEMENT

Management monitors and evaluates the quality and appropriateness of the mobile integrated healthcare service through an active Quality Management (QM) program, including the following:

MIH 02.01.01 A QM flow chart diagram or comparable tool is developed, demonstrating organizational structure in the QM plan and linkage to the Safety Management System.

MIH 02.01.02 The QM plan should emphasize that the quality of services offered is considered on a continuum, with constant attention to developing new strategies for improving. Maintaining the status quo or achieving arbitrary goals are not considered the end-measures.

MIH 02.01.03 The QM program should be integrated and include activities related to patient care (including customer satisfaction and employee satisfaction), service coordination, and all aspects of community MIH operations and equipment maintenance pertinent to the service's mission statement. Involvement with community partners is strongly encouraged.

MIH 02.01.04 There is an ongoing Quality Management (QM) program designed to monitor, assess, and improve the quality and appropriateness of patient care and safety of the community MIH service objectively, systematically, and continuously.

MIH 02.01.05 The QM program includes clinical experts as defined by the program's mission statement and scope of service.

MIH 02.01.06 Promotes the effectiveness of the QM program through active participation by management and staff in the program and by sponsoring active communication pathways bi-directionally between staff and management.

MIH 02.01.07 The QM Program is linked with risk management, so that concerns identified through the risk management program can be followed up through the continuous quality improvement program:

1. There is a written policy that outlines a process to identify, document, and analyze sentinel events, adverse medical events, or potentially adverse events (near misses) with specific goals to improve patient safety and/or quality of patient care

2. There is follow-up on the results of actions/goals for specific events until loop closure is achieved

3. The process encourages personnel to report adverse events even if it is a sole source event (only the individual involved would know about it) without fear of punitive actions for unintentional acts

MIH 02.01.08 The mobile integrated healthcare service has established patient care guidelines/standing orders that must be reviewed annually (for content accuracy) by management, QM Committee members, and the Medical Director(s).

MIH 02.01.09 The Medical Director(s) is responsible for ensuring timely review of patient care.

MIH 02.01.10 There is an established QM program in place that includes:

1. Responsibility/assignment of accountability
2. Scope of care
3. Important aspects of care, including clinical outcomes
4. Operational processes, such as financial outcomes and customer needs
5. Quality indicators (Key Performance Indicators)
6. Thresholds for evaluation appropriate to the individual service
7. Methodology - the QM process or QM tools utilized and how individual indicator scores are measured/calculated
8. Evaluation of the improvement process
9. Assuring integration of care with the patient's physicians and health care system
10. Stakeholder satisfaction surveys
    - Providers
    - Clinical Staff
    - Patients/clients
    - Other Partners

MIH 02.01.11 For both QM and utilization review programs, there should be evidence of action taken in problem areas and evaluation of the effectiveness of that action.

Examples of evidence to meet compliance:
Development of quality metrics that will allow the program to improve in their processes should be developed, with indicators focusing on every aspect of the program (i.e. coordination, clinical, safety, etc.), a flow chart outlining the process flow around outliers, and how the loop is closed to ensure that each outlier is addressed. Subsequent action to trends in activity should be noted with constant

evaluation of the performance improvement process (i.e., Deming Cycle; Plan, Do, Study/Check, Act). The QM plan is current and describes the process with evidence of loop closure in subsequent reports.

MIH 02.01.12 There will be regularly scheduled QM meetings providing a forum for all disciplines involved in the community MIH service to present their needs and areas for improvement to each other. Minutes will be taken and distributed to management and staff not participating in the meetings.

MIH 02.01.13 The monitoring and evaluation process has the following characteristics:

1. Driven by important aspects of care and operational practices identified by the MIH service's QM plan

2. Indicators and thresholds or other criteria are identified to objectively monitor the important aspects of care

3. Evidence of QM studies and evaluation in compliance with written QM plan

4. Evidence of action plans developed when problems are identified through QM, and communication of these plans to the appropriate personnel

5. Evidence of reporting QM activities through established QM organizational structure

6. Evidence of on-going re-evaluation of action plans until problem resolution occurs

7. Evidence of annual, quantitative goals established prospectively for the QM program which provide direction for the work groups. The emphasis must be on loop closure and resolution of problems within a finite period.

MIH 02.01.14 Quarterly review should include at a minimum, but may exceed, criteria based upon the important aspects of care/service. The following examples are encouraged:

1. QM personnel may collect data and refer to the Safety Committee for action and resolution

2. Operational criteria to include, at a minimum, the following quantity indicators:

    a. Number of completed service visits

    b. Number of aborted and canceled service visits (defined as departed but never completed the visit) (i.e.: patient not home, patient refused to be seen, diverted to another location, etc.)

    c. Number of missed services visits and the reasons missed (defined as unable to accept the service request) (i.e.: lack of staff, system capacity, lack of vehicles, etc.)

    d. Number of patients that have "graduated out" and are no longer in need of the program's services

e. Number of visits rescheduled by patient or provider

3. Service visit delays and reasons

4. Changes in patient's condition that required additional interventions

5. Never events (see references)

6. Requests of additional emergency response from EMS, public safety, or emergency psychiatric services

7. Patients with known communicable disease at the time of the request or discovered after the service visit

8. Complaint findings and improvements made

Examples of Evidence to Meet Compliance:
The QM plan is current and describes the process with evidence of loop closure in subsequent reports. QM does not consist only of medical record reviews.

Examples of Evidence to Meet Compliance:
Outcomes from QM should drive systems/process/procedures changes, education, and training needs. Systems improvement tools are educational. The process is not directed toward an individual nor is it punitive.

Tracking and trending of the time between the referral and first encounter and times at the service locations are evaluated in terms of benchmarks set by the program in order to evaluate the effectiveness of policies/procedures, training, and/or equipment needs. If services are delayed, reasons for delays are tracked, as are service requests that are conducted by alternate medical service providers.

MIH 02.02.00 UTILIZATION MANAGEMENT (UM)

Management ensures an appropriate utilization management process through trending and tracking requests. Utilization review may be prospective, concurrent, or retrospective.

MIH 02.02.01 Management ensures an appropriate utilization management process based on:

1. Benefits to the patient (medical, psychosocial, community health)

    a. Timeliness of the services as it relates to the patient's clinical status

    b. Patient care needs consistent with the capabilities and limitations of the community

medical service and the medical providers' skills

c. Patient's own assessment of improvement or impact in quality of life, including pain and discomfort, use of medications, mobility, self-care, patient's out-of-pocket medical expenses, anxiety/depression, and performance of usual activities

2. Safety of the mobile integrated healthcare environment

3. A structured, periodic review of services (to determine service appropriateness, safety, or cost effectiveness over other types of medical care) performed at least semiannually and recorded in a written report. This report indicates criteria have been tracked and trended and feedback was provided when there are inappropriate requests from referral and contacting agencies.

4. Expenditure and cost of care (by patient and in aggregate) (encouraged)

   a. Trending of emergency medical service requests, emergency department visits, hospital and nursing facility inpatient admissions, inpatient days, and physician office visits prior to and following establishment of care by the MIH program

   b. Tracking and trending of patient improvement/changes including patient self-assessment of general health and pre and post intervention (blood pressures, smoking cessation, A1C, BMI, etc.)

   c. Number of program visits

   d. Cost and cost avoidance of emergency department, inpatient care, and physician office visits

   e. Cost of program visits

   f. Source of the referrals

MIH 02.02.02 Management ensures that steps are taken to reduce those services that are considered non-appropriate.

Examples of Evidence to Meet Compliance:
UM reports indicate trending and loop closure of patient outcomes. Requesting agents are contacted if there are trends that indicate over-triage or under-triage. Continuous review of UM with applicable trending and loop closure of patient outcomes in the form of follow-up with receiving facility, documented phone calls to patient/family, etc., may provide adequate information about patient outcome. Outliers should be presented to a QM Committee or during regularly scheduled staff meetings to discuss specifics of the service provided.

MIH 02.03.00 SAFETY MANAGEMENT
(Includes Safety Management Systems and Safety and Environment)

MIH 02.03.01 Safety Management System - Management is responsible for a Safety Management System (SMS) but both management and staff are responsible for ensuring safe operations. The Safety Management System is proactive in identifying risks and eliminating injuries to personnel and patients and damage to equipment and includes:

1. A statement of policy commitment from the accountable executive
2. Designation of a Health and Safety Officer
3. Risk identification process and risk management plan that includes a non-punitive system for employees to report hazards and safety concerns
4. A system to track, trend, and mitigate errors or hazards
5. A system to track and document incident root cause analysis
6. A Safety Manual
7. A system to audit and review organizational policy and procedures, ongoing safety training for all practitioners (including managers), a system of proactive and reactive procedures to insure compliance, etc.
8. A process for dissemination of safety issues to all personnel for loop closure
9. Evidence of management's decisive response to non-compliance in adverse safety or risk situations

    a. Senior leadership should establish a process to identify risk escalation to ensure that safety and risk issues are addressed by the appropriate level of management, up to and including the senior level

    b. Operational Risk Assessment tools should include but not be limited to issues such as: service acceptance, public relations events, and training. For service, the tool should include:

        - Assessing fatigue
        - Clinical acuity of patient
        - Potential risks related to:

            1. Single provider services
            2. Location and environment of the area where services are provided, including safety of the residence or building

3. Other at-risk individuals at the home
4. Communicable disease
5. Use of marked vs unmarked vehicles
6. Use of provider uniforms
7. Proper Use of PPE
8. Bloodborne Pathogen and Needlestick safety
9. Compliance with Ryan White Act

- Foreign language considerations (does the care provider speak the local language)
- Experience of medical provider
- Other temporary situations in areas traveled that may increase risk (for example, extreme weather forecasted, recent/impending political or natural disaster, etc.)

10. Policies that address practitioner safety and include but are not limited to the following examples:

    a. Cultural intelligence
    b. Checking with local law enforcement regarding high-risk areas.
    c. Accountability with respect to the location of the provider, in case of needing assistance (i.e., location tracking, check in, etc.)

11. The program has a process to measure their safety culture by addressing:

    a. Accountability – employees are held accountable for their actions
    b. Authority – those who are responsible have the authority to assess and make changes and adjustments as necessary

        - Standards, policies, and administrative control are evident
        - Written procedures are clear and followed by all
        - Training is organized, thorough, and consistent according to written guidelines

- Managers represent a positive role model, promoting an atmosphere of trust and respect

c. Professionalism – as evidenced by personal pride and contributions to the program's positive safety culture

d. Organizational Dynamics

- Teamwork is evident between management and staff and among the different disciplines, regardless of employer status, as evidenced by open bi-directional and inter-disciplinary communications that are not representative of a "silo" mentality

- Organization represents a practice of encouraging critique and safety observations, and there is evidence of acting upon identified issues in a positive way

- Organization values are clear to all employees and embedded in everyday practice

- Use of Just Culture

12. A Safety Management System includes all disciplines and processes of the organization. A Safety Committee is organized to solicit input from each discipline and should meet at least quarterly, with written reports sent to management and kept on file as dictated by policy.

    a. Safety issues should be identified by the Safety Committee, with detailed reporting and analysis of vehicle/patient safety, travel, and cultural incidents that could potentially affect crew safety and resolution of issues with findings

    b. The committee will promote interaction between medical practitioners and other service providers and staff addressing safety practice, concerns, issues, and questions

    c. There is evidence of action plans, evaluation, and loop closure

13. The Safety Committee is linked to QM and risk management

14. Vehicle related events that occur during a medical visit are identified and tracked to minimize risks (See Glossary in Appendix for definition of event)

    a. Community medical services are required to report accidents to CAMTS and must report to the appropriate government agencies as required. There is a written policy that addresses reporting incidents or accidents and assigns certain individual(s) with the responsibility to report.

MIH 02.04.00 SAFETY AND ENVIRONMENT

MIH 02.04.01 Patient and personnel security

1. A policy addresses the security of the physical environment where services are to be provided

2. A policy addresses cyber security and the protection of program and patient information

3. Personnel security - Medical staff are required to carry program issued photo identification cards with their first and last names and identification as a community health provider. A driver's license and\or passport shall also be carried while on duty. If required by local or state law, the provider's current certification or license identification must also be carried.

4. A comprehensive communications plan addresses two-way communications. The plan may include the use of panic buttons and location identification.

    a. If telecommunication devices (phones, video, text, etc.) are part of the communication equipment, they are to be used in accordance with safety and HIPAA policies

Examples of Evidence to Meet Compliance:
Policy requires wearing or carrying ID's while on duty.

MIH 02.05.00 SAFETY EDUCATION

MIH 02.05.01 Education Specific to Safety of the Mobile Integrated Healthcare Environment - Completion of all the following educational components should be documented. These components should be included in initial education as well as reviewed on an annual basis with all regularly scheduled, part-time or temporarily scheduled medical practitioners as appropriate for the mission statement and scope of practice of the service.

1. Communications strategies and back-up plans

2. Specific capabilities, limitations, and safety measures

3. Situational awareness/technique/equipment that is pertinent to the environment/geographic coverage area of the medical service, including at minimum:

    a. Safety and equipment requirements

    b. Confrontation de-escalation and self defense

    c. Survival training and equipment is strongly encouraged

4. General safety to be included on an annual basis

    a. Driver training and safety if part of the medical provider's responsibilities

    b. Safety around the vehicle and work sites (residences, scenes, homeless shelters, etc.)

    c. Bloodborne pathogen training

    d. Annual fit testing in compliance with NIOSH for respirators

5. General vehicle safety including:

    a. Loading/unloading equipment and supplies

    b. Seat belt use

    c. Securing loose items/equipment

MIH 02.06.00 POST ACCIDENT/INCIDENT PLAN (PAIP)

MIH 02.06.01 The program must maintain a readily accessible post-incident/accident plan so appropriate search efforts may be initiated in the event communications cannot be established with medical practitioners or locations determined within a pre-planned time frame.

1. Written post-incident /accident plans are easily identified, readily available, and understood by all personnel and minimally include:

    a. List of personnel (with current phone numbers) to notify in order of priority (for coordinator to activate) in the event of an incident/accident. This list should include, but not be limited to:

        - Program leadership
        - Risk management/attorney
        - Family members of team members
        - Family of patient
        - Human resources (as applicable)
        - Media relations or pre-identified individual who will be responsible for communicating with the media, state health department, and other team

members

b. A method to insure accurate information dissemination

c. Notification plans include appropriate family members and support services to family members following a tragic event. There must be timely notification of next of kin. Next of kin is no longer strictly defined at the federal level, so the crew member determines this on a data sheet and reviews annually. It is strongly recommended that:

- Family assistance includes coordination of family needs immediately after the event, e.g., transportation, lodging, memorial/burial service, condolences, initial grief support services/referrals (usually through appointment of a family liaison)

- Continuity includes follow through with the family after the event (e.g., the continuation of grief counseling and support referrals, the inclusion of families in decision-making on anniversaries/memorials, and check-ins following release of NTSB reports, or equivalent, etc.)

d. Consecutive guidelines to follow in attempts to:

- Communicate with the medical practitioners

- Initiate support as appropriate (law enforcement, mental health, lift assist, etc.)

- Have a back-up plan for care of the patient

e. Preplanned time frame to activate the post-accident/incident for overdue communication point

f. Procedure to document all notifications, calls, communications and to secure all documents related to the particular incident/accident

g. Procedure to deal with releasing information to the press

h. Resources available for CISD (critical incident stress debriefing) or other counseling alternatives

i. Process to determine whether the program will remain in service

2. An annual drill is conducted to exercise the post-accident/incident plan

MIH 03.00.00 – PATIENT CARE

MIH 03.01.00 SERVICE TYPES AND PROFESSIONAL LICENSURE

Staffing should be commensurate with the mission statement and scope of care of the medical service and potential needs of the patient. A well-developed position description for each discipline is written. The program will have all equipment, medications, interventions, and quality metrics below that are relevant to the program's mission and scope of service (which includes scope of care).

MIH 03.01.01 TYPE I - A Type I service is defined as a program generally focused on discrete tasks and interventions. The program may be standalone or live within a public safety agency or health system.

Preface – Appropriate Authority Having Jurisdiction (AHJ) applies

MIH 03.01.02 Scope of Care – Capability to deliver out of hospital care

1. Formal job descriptions outlining practitioner responsibilities exists. Primary and secondary duties are outlined, if appropriate. Policies outlining how staff duties integrate into agency mission exist.

2. Program focus should be on prevention of illness, improving health, and choosing healthy lifestyles

3. Medical care may be provided as defined in medical protocols. Examples may include:

    a. Multi-agency co-responder programs

    b. EMS community paramedicine services diverting low acuity calls to treatment at home or emergency department diversion

    c. Post-acute follow up

    d. In-home services directed or requested by another agency

    e. Community and social determinants of health resource navigation

    f. Broad education and outreach initiatives

4. Additional program focuses dependent on community needs assessments

5. Additional program focuses dependent on local, state, national, and medical director requirements

6. Scope of Care is reevaluated at a minimum every 2 years, with annual review encouraged.

Periodic Scope of Care reviews are additionally encouraged secondary to community or public health needs.

MIH 03.01.03 Clinical Practitioners

1. Staffing is primarily a single type of practitioner, which may include Community Paramedic, Community Health Workers, Community Emergency Medical Technicians, Healthcare Navigators, Mobile Health Technicians, or similar titles

2. Primary practitioners may consult or partner with other healthcare professionals, as appropriate for the scope of the program

3. Policies exist which outline documentation standards for each practitioner and healthcare partner, as well as protocols for information exchange between programs

4. Equipment and software sufficient for electronic health record documentation and information exchange between healthcare partners

5. All primary practitioners and collaborative partners must be licensed, certified, or permitted according to the appropriate state regulations or by AHJ and have current relicensing, recertification, or re-permitting status

MIH 03.01.04 Equipment and Medications (as appropriate to the mission statement and scope of services)

1. Response Vehicles should include equipment as required by local, state, national requirement, or medical director, and should be appropriate for patient populations served. Examples include but are not limited to:

    a. Emergency patient care supplies: Oral/pharyngeal airway, sphygmomanometer, thermometer, automatic external defibrillator, bag-valve mask, glucometer, oxygen, hemorrhage control supplies, wound care supplies, PPE, scale

    b. Noninvasive monitoring supplies: end tidal carbon dioxide monitoring, EKG monitoring capabilities, pulse oximeter, NIBP

    c. Technology Needs: Wi-Fi/Hotspot capabilities, telehealth devices, printer (Care Plan and Medication list encouraged at each visit)

    d. Medications (depending on local, state, national, or medical director requirements)

        i. Refrigeration and Temperature Capability if vaccinating

        ii. Heat/Cold protective medication storage capability

2. The mobile integrated healthcare service must ensure that all medical equipment is in working order and all equipment/supplies are validated through documented checklists

a. Medical equipment must be periodically tested and inspected, per the manufacturer's requirements, by a certified clinical engineer. Annual inspection is encouraged unless alternative service interval recommended by manufacturer.

b. Equipment inspections will be required according to the program's guidelines and records of inspection maintained

c. Adequate back-up battery supply must be available to ensure all medical equipment remains functional

d. Clinical testing equipment must have a current Clinical Laboratory Improvement Amendment (CLIA) certification or waiver on file

3. Controlled substances provided by the community medical service program are in a secured system or kept in a manner consistent with policy and with local, state, federal, and international regulations, including Drug Enforcement Agency requirements. It is recognized the patient may possess and self-administer their own medications and/or narcotics.

    a. A policy to address securing/storage of controlled substances is required

    b. Storage of medications allows for protection from extreme temperature changes if the environment deems it necessary

    c. There is a method to check expiration dates of medications on a regular basis

    d. There is a procedure or policy for disposing of medications consistent with local, state, or federal law or regulations

    e. There is a procedure or policy for disposing, wasting, or destroying of patient medications when appropriate, consistent with local, state, or federal law or regulations

MIH 03.02.01 TYPE II - A Type II service is defined as a program providing comprehensive care services delivered by a multidisciplinary team. Care may include discrete tasks and interventions, but also must include delivery of advanced clinical care services beyond the scope of traditional paramedicine. Type II services must include responsibility for a broad range of clinical and health outcomes. The program may be standalone or live within a public safety agency or health system and meet all Type I Standards.

Preface – Appropriate Authority Having Jurisdiction (AHJ) applies

MIH 03.02.02 Scope of Care – Capability to deliver out of hospital care

1. Formal job descriptions outlining practitioner responsibilities exists. Primary and secondary duties are outlined, if appropriate. Policies outlining how staff duties integrate into agency mission exist.

2. It is encouraged that some or all program staff are full-time with roles and responsibilities dedicated to the program

3. An organizational chart or outline identifying clinical and operational responsibilities of each role is established

4. Program focus should be on prevention of illness, improving health, choosing healthy lifestyles, and impacting clinical and health outcomes of the population served

5. Medical care may be provided as defined in medical protocols. Examples may include:

    a. Multi-agency co-responder programs addressing mental or chronic health needs

    b. EMS community paramedicine services diverting low acuity calls to treatment at home or emergency department diversion, including the provision of advanced clinical care services and acute disease treatment by appropriately licensed clinicians

    c. Post-acute follow up, including post-discharge clinical care and disease management

    d. In-home advanced clinical care services directed or requested by another agency

    e. Community and social determinants of health assessment and navigation by a licensed clinical social worker or other appropriate clinician

    f. Advanced and Targeted Patient Care Education and outreach

6. Additional programs focused on community needs assessments

7. Additional program focuses on local, state, national, and medical director requirements

8. Scope of Care is reevaluated at a minimum every 2 years, with annual review encouraged. Periodic Scope of Care reviews are additionally encouraged secondary to community or public health needs.

MIH 03.02.03 Clinical Practitioners

1. Staffing includes a multidisciplinary team, which may include:

    a. One or more Community Paramedics, Community Emergency Medical Technicians, or similar titles, **PLUS**

    b. Physicians, Nurse Practitioners, Physician Assistants, or similar providers, **OR**

    c. Mental Health Providers, Community Health Workers, Registered Nurses, Pharmacists, Licensed Clinical Social Workers, Respiratory Therapists, Dieticians, Healthcare Navigators, Mobile Health Technicians, or similar

allied health providers

2. Primary practitioners should regularly consult or partner with other healthcare professionals, as appropriate for the scope of the program

    a. Policies exist which outline documentation standards for each practitioner and healthcare partner, as well as protocols for information exchange between programs

    b. Equipment and software sufficient for electronic health record documentation and information exchange between healthcare partners

    c. Informatics capabilities appropriate for longitudinal tracking of patient data

        i. Formal capture, measurement, and reporting of clinical and health outcomes data

        ii. Policies and/or contractual agreements linking outcomes to operations and/or financial program support

        iii. All primary practitioners and collaborative partners must be licensed, certified, or permitted according to the appropriate state regulations or by AHJ and have current relicensing, recertification, or re-permitting status

MIH 03.02.04 Equipment and Medications (as appropriate to the mission statement and scope of services)

1. Response Vehicles should include equipment as required by local, state, national, or medical director. Examples include but are not limited to:

    a. Emergency patient care supplies: Oral/pharyngeal airway, sphygmomanometer, thermometer, automatic external defibrillator, bag-valve mask, glucometer, oxygen, hemorrhage control supplies, wound care supplies, PPE, scale

    b. Noninvasive monitoring supplies: end tidal carbon dioxide monitoring, EKG monitoring capabilities, pulse oximeter, NIBP

    c. Advanced clinical care supplies: Remote Patient Monitoring equipment and supplies, Point of Care testing supplies, phlebotomy and lab specimen collection materials, ostomy, and catheter supplies

    d. Technology Needs: Wi-Fi/Hot Spot capabilities, telehealth devices, printer (Care Plan and Medication list encouraged at each visit)

    e. Medications (depending on local, state, national or medical director requirements)

        i. Refrigeration and temperature capability if vaccinating

        ii. Heat/Cold protective medication storage capability

2. The mobile integrated healthcare service must ensure that all medical equipment is in working order and all equipment/supplies are validated through documented checklists

    a. Medical equipment must be periodically tested and inspected, per the manufacturer's requirements, by a certified clinical engineer. Annual inspection is encouraged unless alternative service interval recommended by manufacturer.

    b. Equipment inspections will be required according to the program's guidelines

    c. Adequate back-up battery supply must be available to ensure all medical equipment remains functional

    d. Clinical testing equipment must have a current Clinical Laboratory Improvement Amendment (CLIA) certification or waiver on file

3. Controlled substances provided by the community medical service program are in a secured system or kept in a manner consistent with policy and with local, state, federal and international regulations, including Drug Enforcement Agency requirements. It is recognized the patient may possess and self-administer their own medications and/or narcotics.

    a. A policy to address securing/storage of controlled substances is required

    b. Storage of medications allows for protection from extreme temperature changes if the environment deems it necessary

    c. There is a method to check expiration dates of medications on a regular basis

    d. There is a procedure or policy for disposing of medications consistent with local, state, or federal law or regulations

    e. There is a procedure or policy for disposing, wasting, or destroying of patient medications when appropriate consistent with local, state, or federal law or regulations

MIH 03.03.00 MEDICAL DIRECTION

Medical Director(s)

The medical director(s) of the program is a physician who is responsible for supervising and evaluating the quality of medical care provided by all paramedicine or mobile integrated health team members. The medical director ensures, by working with the clinical supervisor and by being familiar with the scope of practice of the MIH members and the regulations in which the care team practices, competency and currency of all medical practitioners working with the service. Co-Medical Director roles are encouraged if and when it better ensures familiarity and expertise with scope of practice and clinical care services delivered by the team.

MIH 03.03.01 The medical director(s) should be licensed and authorized to practice in the state and location in which the medical service is based.

1. The medical director(s) should be board-certified as appropriate to the program's scope of services and have experience in those areas of medicine that are commensurate with the mission statement and scope of care of the MIH-service (i.e., adult, pediatric, newborn, etc.) or utilize specialty physicians as consultants when appropriate

MIH 03.03.02 The medical director should be current and demonstrate competency or provide documentation of equivalent educational experiences directed by the mission statement and scope of care. Certifications are required as pertinent to the program's scope of care. For those services based in emergency medical services, the medical director(s) should be board-certified in Emergency Medicine and/or Emergency Medical Services. If a physician is board-certified in emergency medicine, certification #1 is optional; if a physician is board-certified in pediatric emergency medicine, certification #2 is optional.

Supporting Education and Competency Criteria: Medical Director(s)

COMPETENCY AREA 1: Emergency Medical Services

1. Advanced Cardiac Life Support (ACLS) according to the current standards of the American Heart Association or approved equivalent

2. Pediatric Advanced Life Support (PALS) according to the current standards of the American Heart Association (AHA) or Advanced Pediatric Life Support (APLS) according to the current standards of the American College of Emergency Physicians (ACEP) or national equivalent (if pediatrics is part of the scope of care)

3. Vehicle and Equipment Operations (if relevant to scope)

COMPETENCY AREA 2: Education Specific to MIH Environment

COMMUNITY BASED NEEDS

1. Knowledge of the local community needs assessment

2. Social determinants of health

3. Cultural competencies (Religion, Language, Sexual Orientation, Ethnicity, Race)

4. At risk needs (physical and mental abuse, neglect, PTSD, malnutrition, medical illiteracy, fall risk)

INTERDISCIPLINARY COLLABORATION

1. Developing Plans of Care and Care coordination

2. Development of exit strategies to discontinue services when no longer needed or appropriate

3. Palliative care/end of life care

PATIENT-CENTRIC CARE

1. Chronic disease and management
2. Pharmacology and medication management strategies
3. Medication Safety and Error Prevention
4. Mental and Behavioral Health
5. Substance Use Disorders
6. Education for procedural activities based on scope of program (Wound care, use of durable medical equipment (DME), catheter placement/replacement)
7. Use of Medical Equipment, Point of Care testing equipment, Remote Patient Monitoring Equipment, and Lab Specimen Equipment, as appropriate
8. Patient care capabilities and limitations (i.e., assessment and invasive procedures)
9. Telemedicine/telehealth use and equipment as appropriate

COMPETENCY AREA 3: Human Factors and Personnel Management

1. Crew resource management and safety and risk management education
2. Compassion fatigue and professional boundary setting
3. Psychological first aid and stress recognition and management/resilience
4. Promotion of healthy lifestyle, recognizing signs of fatigue, fitness for duty
5. “Just Culture” or equivalent education is strongly encouraged
6. Knowledge of Employee Assistance Program (EAP)

COMPETENCY AREA 4: General Operations

1. Communication operations and procedures
2. Infection control and use of personal protective equipment
3. Compliance issues and regulations

4. Appropriate privacy and HIPAA considerations
5. Quality Management and appropriate utilization of MIH services
6. Post Accident Incident Plan (PAIP)
7. Knowledge of submitting grants, Request for Proposals, Request for Application
8. Data collection, interpretation, and analysis
9. Budgeting and financial sustainability

MIH 03.03.03 The medical director(s) is actively involved in the quality management (QM) program for the service.

MIH 03.03.04 The medical director(s) is actively involved in administrative decisions affecting medical care for the service.

MIH 03.03.05 The medical director(s) establishes written criteria for patient enrollment into the MIH program.

MIH 03.03.06 The medical director sets and annually reviews clinical practice guidelines for scope of care provided by the MIH team and clinicians. Guidelines are in a written format and include an updated attestation signed and dated by the medical director. Input from the multidisciplinary team members is strongly encouraged.

MIH 03.03.07 The medical director(s) is actively involved in the hiring process, training, and continuing education of all medical practitioners for the service, including involvement in skills labs, medical protocols, or guideline changes or additions.

MIH 03.03.08 The medical director ensures those recommending or caring for patients in the program are provided with written periodic updates of the patient care provided by the community medical service and acts as a liaison with those physicians or agencies when needed.

Examples of Evidence to Meet Compliance:
There is evidence of the medical director's involvement with the program through meeting attendance records, education records, chart reviews, etc.

MIH 03.03.09 The medical director(s) ensures patient care plans are appropriate and safe for the patient's specific disease process/needs. The medical director ensures that care is coordinated between the MIH practitioner and their physicians/health system, and that the care does not exceed the scope of practice of the practitioner.

MIH 03.03.10 The medical director must maintain open communications with referring and accepting agents and be accessible for concerns expressed regarding controversial issues and patient management.

MIH 03.03.11 The medical director will encourage research into best practices and contribute to published literature.

MIH 03.03.12 Medical Oversight

1. If the medical director is unavailable, there are other physicians (who are trained and identified by the service) with the appropriate knowledge base to ensure proper medical care and medical oversight during care for all patient types served by the MIH service

Examples of Evidence to Exceed Compliance:
The medical director is involved in mobile integrated healthcare on a regional and/or national basis. The medical director participates in peer-reviewed published research regarding mobile integrated healthcare.

MIH 03.04.00 CLINICAL CARE SUPERVISORS AND PROGRAM MANAGERS

Programs are required to have either a Clinical Care Supervisor or a Program Manager. Depending on scope of services, Type I Programs can assign this role to a practitioner, provided responsibilities are defined. Both a clinical care supervisor and program manager are encouraged for Type II Programs, though a blended role may be established to address leadership responsibilities of both roles.

1. Programs with blended roles must ensure training and competency criteria for each role are met accordingly

MIH 03.04.01 The clinical care supervisor should demonstrate currency in the following or equivalent educational experiences, as appropriate to the mission statement and scope of care:

1. Responsibility for supervision of patient care provided by the various clinical care providers (i.e., RN, PA, RT, EMT, Paramedic, etc.) must be defined by the service
2. All patient care practitioners must be supervised by someone knowledgeable and legally enabled to perform clinical supervision
3. The clinical care supervisor and medical director(s) must work collaboratively to coordinate the patient care delivery given by the various professionals and to review the overall system for delivery of patient care
4. Policies ensure that clinical competency is maintained by currency in the following or equivalent training as appropriate

COMPETENCY AREA 1: Emergency Medical Services

1. Advanced Cardiac Life Support (ACLS) – documented evidence of current ACLS according to the American Heart Association (AHA)
2. Basic Life Support (BLS) - documented evidence of current BLS certification according to the AHA

3. Pediatric Advanced Life Support (PALS) according to the AHA - or Advanced Pediatric Life Support (APLS) according to ACEP, or equivalent education (if pediatrics is part of the scope of care)
4. Neonatal Resuscitation Program (NRP) if scope of care includes care of infants 28 days old or less
5. EMT/paramedic certifications (EMT, paramedic, CCP-C) must be current if required by position description
6. Certified Community Paramedic (CP-C) for eligible clinicians is strongly recommended within two (2) years of date of hire
7. Vehicle and Equipment Operation Training

COMPETENCY AREA 2: Education Specific to MIH Environment

COMMUNITY BASED NEEDS

1. Knowledge of the local community needs assessment
2. Social determinants of health
3. Cultural competencies (Religion, Language, Sexual Orientation, Ethnicity, Race)
4. At risk needs (physical and mental abuse, neglect, malnutrition, medical illiteracy, fall risk)
5. Home safety assessment
6. Public and/or Population Health (as appropriate to scope of care)
7. Scope and roles of other community resources (Public health, other clinical and non- clinical community-based organizations)

INTERDISCIPLINARY COLLABORATION

1. Developing Plans of Care and Care coordination
2. Development of exit strategies to discontinue services when no longer needed or appropriate
3. Palliative care/end of life care

PATIENT-CENTRIC CARE

1. Anatomy, physiology, and assessment for adult, pediatric, and neonatal patients as applicable
2. Chronic disease and management

3. Pharmacology and medication management strategies
4. Medication Safety and Error Prevention
5. Mental and Behavioral Health
6. Substance Use Disorders
7. Neonatal, pediatric, and geriatric medicine and adaptive technology (as appropriate of scope of care)
8. Trauma informed care, including PTSD and harm reduction
9. Crisis communication and intervention training (if program scope includes mental health response)
10. Education for procedural activities based on scope of program (wound care, use of durable medical equipment (DME), catheter placement/replacement)
11. Use of Medical Equipment, Point of Care testing equipment, Remote Patient Monitoring Equipment, and Lab Specimen Equipment, as appropriate
12. Patient care capabilities and limitations (i.e., assessment and invasive procedures)
13. Telemedicine/telehealth use and equipment as appropriate

PREVENTATIVE CARE AND PATIENT EDUCATION

1. Motivational interviewing
2. Knowledge of wellness and health teaching
3. Prevention (Immunizations and screening, physical safety, personal risks)
4. Additional education related to the program's specialty

COMPETENCY AREA 3: Human Factors and Personnel Management

1. Crew resource management and safety and risk management education
2. Compassion fatigue and professional boundary setting
3. Psychological first aid and stress recognition and management/resilience
4. Promotion of healthy lifestyle, recognizing signs of fatigue, fitness for duty
5. "Just Culture" or equivalent education is strongly encouraged
6. Knowledge of the Employee Assistance Program (EAP)

COMPETENCY AREA 4: General Operations

1. Communication operations and procedures
2. Infection control and use of personal protective equipment
3. Compliance issues and regulations
4. Technology use and troubleshooting
5. Appropriate privacy and HIPAA considerations
6. Quality Management and appropriate utilization of MIH services
7. Post Accident Incident Plan (PAIP)
8. Knowledge of submitting grants, Request for Proposals, Request for Application
9. Data collection, interpretation, and analysis
10. Budgeting and financial sustainability
11. Knowledge of the community health assessment process

Continuing education/staff development - Continuing education must be provided and documented in the four competency areas. This includes didactic and practical clinical continuing education.

1. Skills maintenance program documented to comply with the number of skills required in a set period of time, according to policy of the MIH service
2. Appropriate clinical experiences pertinent to the MIH program's scope of care

Clinical competency must be maintained by currency of certifications/licensure as appropriate for the position description, mission statement, and scope of care of the MIH service.

MIH 03.04.02 Program Managers may have overall responsibility for a program or for a specific base with or without additional clinical responsibilities. (Follow criteria above if clinical responsibilities are part of the position description.)

1. The program manager must demonstrate currency in the following or equivalent educational experiences as appropriate to the mission statement and scope of care. Didactic and practical education initially and on an annual basis should include, but not be limited to:

COMPETENCY AREA 2: Education Specific to MIH Environment

COMMUNITY BASED NEEDS

1. Knowledge of the local community needs assessment

2. Social determinants of health
3. Cultural competencies (Religion, Language, Sexual Orientation, Ethnicity, Race)
4. At risk needs (physical and mental abuse, neglect, PTSD, malnutrition, medical illiteracy, fall risk)
5. Home safety assessment
6. Public and/or Population Health (as appropriate for scope of care)
7. Scope and roles of other community resources (Public health, other clinical and non- clinical community-based organizations)

INTERDISCIPLINARY COLLABORATION

1. Developing Plans of Care and Care coordination
2. Development of exit strategies to discontinue services when no longer needed or appropriate
3. Palliative care/end of life care

PATIENT-CENTRIC CARE

1. Protocols and compliance measures for maintaining medication safety and error prevention
2. Protocol adaptations and resources relevant to mental and behavioral health and substance use disorder needs
3. Crisis communication and intervention training (if program scope includes mental health response)
4. Use of Medical Equipment, Point of Care testing equipment, Remote Patient Monitoring Equipment, and Lab Specimen Equipment, as appropriate
5. Patient care capabilities and limitations (i.e., assessment and invasive procedures)
6. Telemedicine/telehealth use and equipment as appropriate

PREVENTATIVE CARE AND PATIENT EDUCATION

1. Motivational interviewing
2. Additional education related to the program's specialty

<u>COMPETENCY AREA 3: Human Factors and Personnel Management</u>

1. Crew resource management and safety and risk management education
2. Compassion fatigue and professional boundary setting

3. Psychological first aid and stress recognition and management/resilience
4. Promotion of healthy lifestyle, recognizing signs of fatigue, fitness for duty
5. "Just Culture" or equivalent education is strongly encouraged
6. Knowledge of the Employee Assistance Program (EAP)

COMPETENCY AREA 4: General Operations

1. Communication operations and procedures
2. Infection control and use of personal protective equipment
3. Compliance issues and regulations
4. Technology use and troubleshooting
5. Appropriate privacy and HIPAA considerations
6. Quality Management and appropriate utilization of MIH services
7. Post Accident Incident Plan (PAIP)
8. Knowledge of submitting grants, Request for Proposals, Request for Application
9. Data collection, interpretation, and analysis
10. Budgeting and financial sustainability
11. Knowledge of the community health care assessment process

MIH 03.04.03 The Clinical care supervisor(s) and Program Manager(s) are actively involved in the QM process.

MIH 03.04.04 Knowledge of national regulations as appropriate to scope of practice.

MIH 03.05.00 ORIENTATION AND CONTINUING EDUCATION

A planned and structured program is required for all regularly scheduled primary providers. Currency in these competencies must be ensured and documented through relevant continuing education programs/certification programs or their equivalent listed in this section. The orientation, training, and continuing education must be directed and guided by the program's scope of care and patient population, mission statement, and medical direction.

MIH 03.05.01 Type I Program

1. Initial Training Program - Each Type I Program Service provider must successfully complete a comprehensive training program or show proof of recent experience/training in the

categories listed below prior to assuming independent responsibility

a. Both didactic and practical clinical training is required

i. Didactic and practical training are required in each of the four (4) competency areas

ii. Programs may decide which topics within each competency area will be didactic or practical based on the scope of the program

iii. Didactic and Practical training shall be no less than 80 hours in total for initial training standards

b. All competency categories below are required unless program scope excludes necessity

c. Programs are encouraged to modify clinical topic areas based on program scope

Supporting Education and Competency Criteria: Type I Practitioners

COMPETENCY AREA 1: Emergency Medical Services

1. Advanced Cardiac Life Support (ACLS) – documented evidence of current ACLS according to the American Heart Association (AHA)
2. Basic Life Support (BLS) - documented evidence of current BLS certification according to the AHA
3. Pediatric Advanced Life Support (PALS) according to the AHA - or Advanced Pediatric Life Support (APLS) according to ACEP, or equivalent education (if pediatrics is part of the scope of care)
4. Neonatal Resuscitation Program (NRP) if scope of care includes care of infants 28 days old or less
5. EMT/paramedic certifications (EMT, paramedic, CCP-C) must be current if required by position description
6. Certified Community Paramedic (CP-C) for eligible clinicians is strongly recommended within two (2) years of date of hire
7. Vehicle and Equipment Operation Training

COMPETENCY AREA 2: Education Specific to MIH Environment

COMMUNITY BASED NEEDS

1. Knowledge of the local community needs assessment
2. Social determinants of health
3. Cultural competencies (Religion, Language, Sexual Orientation, Ethnicity, Race)
4. At risk needs (physical and mental abuse, neglect, malnutrition, medical illiteracy, fall risk)
5. Home safety assessment
6. Public and/or Population Health (as appropriate to scope of care)
7. Scope and roles of other community resources (Public health, other clinical and non- clinical community-based organizations)

INTERDISCIPLINARY COLLABORATION

1. Developing Plans of Care and Care coordination
2. Development of exit strategies to discontinue services when no longer needed or appropriate.
3. Palliative care/end of life care

PATIENT-CENTRIC CARE

1. Anatomy, physiology, and assessment for adult, pediatric, and neonatal patients as applicable
2. Chronic disease and management
3. Pharmacology and medication management strategies
4. Medication Safety and Error Prevention
5. Mental and Behavioral Health
6. Substance Use Disorders
7. Neonatal, pediatric, and geriatric medicine and adaptive technology (as appropriate to scope of care)
8. Trauma informed care, including PTSD and harm reduction
9. Crisis communication and intervention training (if program scope includes mental health response)
10. Education for procedural activities based on scope of program (wound care, use of durable medical equipment (DME), catheter placement/replacement)

11. Use of Medical Equipment, Point of Care testing equipment, Remote Patient Monitoring Equipment, and Lab Specimen Equipment, as appropriate
12. Patient care capabilities and limitations (i.e., assessment and invasive procedures)
13. Telemedicine/telehealth use and equipment as appropriate.

PREVENTATIVE CARE AND PATIENT EDUCATION

1. Motivational interviewing
2. Knowledge of wellness and health teaching
3. Prevention (Immunizations and screening, physical safety, personal risks)
4. Additional education related to the program's specialty

COMPETENCY AREA 3: Human Factors and Personnel Management

1. Crew resource management and safety and risk management education
2. Compassion fatigue and professional boundary setting
3. Psychological first aid and stress recognition and management/resilience
4. Promotion of healthy lifestyle, recognizing signs of fatigue, fitness for duty
5. "Just Culture" or equivalent education is strongly encouraged
6. Knowledge of the employee assistance program (EAP)

COMPETENCY AREA 4: General Operations

1. Communication operations and procedures
2. Infection control and use of personal protective equipment
3. Compliance issues and regulations
4. Technology use and troubleshooting
5. Appropriate privacy and HIPAA considerations
6. Quality Management and appropriate utilization of MIH services
7. Post Accident Incident Plan (PAIP)

Continuing education/staff development - Continuing education must be provided and documented in the four competency areas. This includes didactic and practical/ clinical continuing education.

1. Skills maintenance program documented to comply with the number of skills required in a set period of time, according to policy of the MIH service

2. Appropriate clinical experiences pertinent to the MIH program's scope of care

Clinical competency must be maintained by currency of certifications/licensure as appropriate for the position description, mission statement, and scope of care of the MIH service.

MIH 03.05.02 Type II Program

1. Initial Training Program - Each Type II Program Service provider must successfully complete a comprehensive training program or show proof of recent experience/training in the categories listed below prior to assuming independent responsibility

    a. Both didactic and practical clinical training is required

        i. didactic and practical training is required in each of the four (4) competency areas

        ii. Programs may decide which topics within each competency area will be didactic or practical based on the scope of the program

        iii. Didactic and Practical training shall be no less than 80 hours in total for initial training standards

    b. All competency categories below are required unless program scope excludes necessity

    c. Programs are encouraged to modify clinical topic areas based on program scope

Supporting Education and Competency Criteria: Type II Practitioners

COMPETENCY AREA 1: Emergency Medical Services

1. Advanced Cardiac Life Support (ACLS) – documented evidence of current ACLS according to the American Heart Association (AHA)

2. Basic Life Support (BLS) - documented evidence of current BLS certification according to the AHA

3. Pediatric Advanced Life Support (PALS) according to the AHA - or Advanced Pediatric Life Support (APLS) according to ACEP, or equivalent education (if pediatrics is part of the scope of care)

4. Neonatal Resuscitation Program (NRP) if scope of care includes care of infants 28 days old or less

5. EMT/paramedic certifications (EMT, paramedic, CCP-C) must be current if required by position description
6. Certified Community Paramedic (CP-C) for eligible clinicians is strongly recommended within two (2) years of date of hire
7. Vehicle and Equipment Operation Training

COMPETENCY AREA 2: Education Specific to MIH Environment

COMMUNITY BASED NEEDS

1. Knowledge of the local community needs assessment
2. Social determinants of health
3. Cultural competencies (Religion, Language, Sexual Orientation, Ethnicity, Race)
4. At risk needs (physical and mental abuse, neglect, malnutrition, medical illiteracy, fall risk)
5. Home safety assessment
6. Public and/or Population Health (as appropriate to scope of care)
7. Scope and roles of other community resources (Public health, other clinical and non- clinical community-based organizations)

INTERDISCIPLINARY COLLABORATION

1. Developing Plans of Care and Care coordination
2. Development of exit strategies to discontinue services when no longer needed or appropriate
3. Palliative care/end of life care

PATIENT-CENTRIC CARE

1. Anatomy, physiology, and assessment for adult, pediatric, and neonatal patients as applicable
2. Chronic disease and management
3. Pharmacology and medication management strategies
4. Medication Safety and Error Prevention
5. Mental and Behavioral Health
6. Substance Use Disorders

7. Neonatal, pediatric, and geriatric medicine and adaptive technology (as appropriate to scope of care)
8. Trauma informed care, including PTSD and harm reduction
9. Crisis communication and intervention training (if program scope includes mental health response)
10. Education for procedural activities based on scope of program (wound care, use of durable medical equipment (DME), catheter placement/replacement)
11. Use of Medical Equipment, Point of Care testing equipment, Remote Patient Monitoring Equipment, and Lab Specimen Equipment, as appropriate
12. Patient care capabilities and limitations (i.e., assessment and invasive procedures)
13. Telemedicine/telehealth use and equipment as appropriate

PREVENTATIVE CARE AND PATIENT EDUCATION

1. Motivational interviewing
2. Knowledge of wellness and health teaching
3. Prevention (Immunizations and screening, physical safety, personal risks)
4. Additional education related to the program's specialty

COMPETENCY AREA 3: Human Factors and Personnel Management

1. Crew resource management and safety and risk management education
2. Compassion fatigue and professional boundary setting
3. Psychological first aid and stress recognition and management/resilience
4. Promotion of healthy lifestyle, recognizing signs of fatigue, fitness for duty
5. "Just Culture" or equivalent education is strongly encouraged
6. Knowledge of the employee assistance program (EAP)

COMPETENCY AREA 4: General Operations

1. Communication operations and procedures
2. Infection control and use of personal protective equipment
3. Compliance issues and regulations
4. Technology use and troubleshooting

5. Appropriate privacy and HIPAA considerations

6. Quality Management and appropriate utilization of MIH services

7. Post Accident Incident Plan (PAIP)

Continuing education/staff development - Continuing education must be provided and documented in the four competency areas. This includes didactic and practical/ clinical continuing education.

1. Skills maintenance program documented to comply with the number of skills required in a set period of time, according to policy of the MIH service

2. Appropriate clinical experiences pertinent to the MIH program's scope of care

Clinical competency must be maintained by currency of certifications/licensure as appropriate for the position description, mission statement, and scope of care of the MIH service.

MIH 03.06.00 ACCOMMODATIONS AT THE PATIENT CARE LOCATION

MIH 03.06.01 Patient care locations should not compromise the ability to receive appropriate care if necessary.

1. Policies that address patient placement should allow for safe egress

2. Policies that address barrier protection of medical equipment and supplies in non-health care locations

3. Accessible to soap and water or disinfectant

MIH 03.06.02 Policy will address methods and options for assuring patient privacy at the care location.

MIH 03.06.03 Operational Issues

1. Occupant restraint devices - Medical practitioners must use seat belts at all times while vehicles are in motion

2. Policy addressing the provision of contingency plans in the event of maintenance problems, adverse weather, changes in security issues, delays extending duty time beyond 12 hours, and other adverse occurrences. The policy will list resources available to personnel should these situations arise.

3. A policy sets criteria and guidelines for discontinuing or terminating patient care services, including procedures and criteria for aborting a patient encounter prior to and during patient care. The policy should include a review process that includes both clinical and administrative staff.

4. A policy that addresses do not resuscitate (DNR)/allow natural death (AND)/physician's orders for life sustaining treatment (POLST)

5. A policy addresses transfer and security of patient's personal property if the patient must be moved

6. A policy outlining procedures in the circumstance a patient needs emergent care that cannot be provided by the practitioner.

7. A policy addressing a Post Accident Incident Plan (PAIP) with initial and ongoing training requirements

MIH 03.07.00 INFECTION CONTROL AND PREVENTION

Policies and procedures addressing patient care issues involving communicable diseases, infectious processes, and health precautions for emergency personnel as well as for patients must be current with the local standard of practice or national standards (or in the U.S. - OSHA and as published by the Centers for Disease Control and Prevention).

MIH 03.07.01 Policies and procedures must be written and readily available to all personnel of the MIH service.

MIH 03.07.02 There is an Exposure Control Plan consistent with national (in the U.S., OSHA) guidelines. The ECP includes:

1. A reference for work restrictions for personnel exposed to or infected with an infectious disease (reference Table 2.2 in Guide to Infection Prevention in EMS)

2. A list of the risks associated with diseases prevalent in coverage areas specific to the program

3. A bloodborne pathogen program consistent with the OSHA Bloodborne Pathogen Standard (http://www.osha.gov/SLTC/blodbornepathogens/bloodborne_quickref.html)

MIH 03.07.03 Education programs will include the program's infection control resources, programs, policies, and CDC and OSHA recommendations (or equivalent national guidelines). In addition, initial and annual education regarding identification, management, and safety related to patients with potentially infectious pathogens is documented.

MIH 03.07.04 Education programs and policies regarding latex allergies may include:

1. Patients and employees at risk for latex sensitivities and symptoms manifested by an allergic reaction

2. Maintaining a latex-safe environment

3. Methods to minimize latex exposure to lessen risks of allergic reactions in clinical personnel

MIH 03.07.05 Preventive measures - All personnel must practice preventive measures lessening the likelihood of transmission of pathogens. Policies and procedures address:

1. Personnel health concerns and records of:

    a. Pre-employment and annual physical exams or medical screening to include:

        - History of acute or chronic illnesses

        - Illnesses requiring use of medications that may cause drowsiness, affect judgment or coordination

        - Provide annual tuberculosis testing (purified protein derivative), especially if services are provided in high-risk areas and other testing, screenings, and vaccinations as consistent with current national (CDC in the U.S.) guidelines. The CDC may deem the localized region low risk and annual testing not necessary, but this applies only if the service does not operate or respond outside of the local region.

        - Immunization history appropriate to the scope of practice. Practitioners are encouraged to have tetanus immunization (Measles, mumps, and rubella (MMR) immunizations are encouraged for those born after 1957.) “Hepatitis B vaccine must be offered and if the employee has not previously had the vaccination or does not have adequate titers and declines, the program must have a signed declination form per OSHA or equivalent standard. The flu and other preventative vaccines, as recommended by the CDC, are required unless contraindicated by policy.

        - Immunization history is documented and monitored for currency and appropriateness

2. Management of communicable diseases and infection control in the community MIH environment is outlined in policies

    a. Personal protective equipment is readily accessible in the service vehicle or issued to the medical team. Available protective equipment must include gloves, gowns, masks, shoe coverings, and eye/face protection.

        i. Annual fit testing must be completed, as appropriate

        ii. Reusable equipment must be inspected and maintained following the manufacturer’s instructions

b. Use of safety needles and blunt or other type system to lessen the risk of needlesticks to those who may come into contact with them

c. Sharps disposal container for contaminated needles and collection container for soiled disposable items on the vehicle and at the care sites, and proper disposal of same

d. Cleaning and disinfecting with appropriate disinfectant of the equipment and of personnel's soiled clothes

e. Proper cleaning or sterilization of all appropriate instruments or equipment following each patient contact

f. Hand hygiene is performed before and after touching a patient, before clean/aseptic procedures, after body fluids exposure risk, after touching patient's surroundings, before handling medications, after leaving the care site, and before and after removing gloves

    i. Hand washing with an antimicrobial soap and water is indicated when hands are visibly soiled, contaminated with proteinaceous material or exposed to body fluids. However, it is recognized that this may not be possible in the community MIH environment, in which case an alcohol-based hand rub should be used. An alcohol-based hand rub is preferred for all other hand hygiene.

g. Management maintains documentation related to bloodborne and airborne pathogens, including confidential records of exposure incidents and post-exposure follow-up, hepatitis B vaccination status, and initial and on-going training for all employees

h. Post exposure follow-up includes identification and testing of source patient, baseline, and follow-up testing of exposed employee, making counseling resources available, and offering Hepatitis B vaccination

    i. A policy addresses access to post exposure prophylaxis (PEP) medications for HIV, meningococcal infections, etc. The PEP medications should be available in a timely manner for all team members.

    ii. A policy addresses separation of dirty supplies and clean supplies/equipment in the vehicle and home base

    iii. Policies or protocols address infection protection in the home or care setting

    iv. Policy or protocol address safely disposing of medical waste (syringes, test strips)

MIH 04.00.00 - VEHICLE OPERATIONS

MIH 04.01.00 Vehicle Operations

For those program's using program owned vehicle(s) the following standards apply. For those program's using personal owned vehicles, policies need to address safe operations and reflect a professional image and may include those listed in this section.

MIH 04.01.01 The vehicle will be licensed in accordance with the applicable authority having jurisdiction (AHJ) laws and regulations.

MIH 04.01.02 There is a written policy that addresses speed limitations and all aspects of traffic law compliance that pertain to vehicle operations.

MIH 04.01.03 There is a written policy that addresses a procedure to follow when the vehicle comes upon an accident scene. Policy must be consistent with state regulations.

MIH 04.01.04 There is a written policy that outlines a procedure to follow when the vehicle is involved in an accident with damage and/or injuries.

MIH 04.01.05 There is a written policy outlining the procedure for a mandatory drug test of the vehicle operator after an accident with an injury or serious damage.

MIH 04.01.06 There is a written policy outlining the procedure to follow when the vehicle breaks down.

MIH 04.01.07 There is a written policy dealing with safety aspects of operating a vehicle:

1. Vehicle operator duty and rest time

2. Inclement weather and responsibility for aborting the patient encounter if there is a safety concern

3. Driving and operator records (speeding and other traffic violations) are reviewed by management minimally upon hire and then annually

MIH 04.02.00 VEHICLE AND EQUIPMENT

MIH 04.02.01 The vehicle is equipped with road hazard equipment to be used in the event of a breakdown.

1. Road hazard equipment must minimally include:

    a. Flashlight

    b. Road marking device – cones, flares, or triangles, for example

c. High-visibility reflective vests (one for each potential occupant) or appropriate Department of Transportation (DOT)-approved clothing worn by medical practitioners in accordance with ANSI-SEA 107 standard or equivalent national standard (required for medical personnel and vehicle operators responding to or stopping at night scenes or breakdowns on the highway)

d. Equipment for dealing with snow as appropriate to the environment

MIH 04.02.02 A secondary means of communication, other than a cell phone, is encouraged.

MIH 04.02.03 Radio frequencies are consistent with the state EMS radio communications plans.

MIH 04.02.04 Internet access.

MIH 04.02.05 If oxygen or other compressed gases are carried, an appropriate securing device must be installed to keep the tank(s) secure during vehicle movement.

MIH 04.02.06 If carried, controlled substances are in a locked system and kept in a manner consistent with local and national regulation.

MIH 04.02.07 Storage of medications allows for protection from extreme temperature changes.

MIH 04.02.08 Securing Equipment

- All medical equipment supplies and ancillary equipment (charges, battery packs, etc.) must be secured to prevent them from becoming a projectile in the event of turbulence or a crash
- Velcro is not to be used to secure equipment or devices
- If straps or belts are used to secure equipment, they must be rated to keep the weight and configuration in place to a minimum of a G-force of five
- Rated cargo nets are strongly preferred over individual straps or belts to secure equipment bags

MIH 04.03.00 WEATHER

MIH 04.03.01 There must be a written policy addressing weather/environmental conditions that prohibit vehicle use, such as zero/zero visibility and highway patrol road closures.

MIH 04.04.00 VEHICLE OPERATOR

MIH 04.04.01 Vehicle operator must have a minimum of 2 years' experience as a licensed driver,

MIH 04.04.02 Vehicle operators are required to complete defensive driving training program that is developed by the provider or outside agency.

MIH 04.04.03 Operators of boats or other surface vehicles must demonstrate completion of initial training.

MIH 04.04.04 The defensive driving training program must be repeated for each vehicle operator at least every 2 years or more frequently if involved in an “at fault” accident.

MIH 04.04.05 Vehicle “co-pilot” responsibilities and duties (if more than one person is on board):

1. Vehicle co-pilot will have assigned duties to support the vehicle operator
    a. In navigation – setting/verifying GPS input
    b. Monitoring vehicle operator fatigue/impairment – the vehicle co-pilot is expected to stay alert at all times while the vehicle is in motion
    c. Non-essential cell phone and computer are prohibited during vehicle operation

MIH 04.05.00 VEHICLE MAINTENANCE

MIH 04.05.01 Each vehicle must be maintained in full operating condition and in good repair, and documentation of maintenance must be kept on file. In addition, there must be a regular documented preventive maintenance program in accordance with the requirements of the manufacturer and other regulatory agencies.

1. There are documented daily checks of the vehicle for damages and equipment failure
2. Major vehicle fluid and tire pressure checks are completed twice a week at a minimum

MIH 04.05.02 There must be no evidence of damage penetrating the body of the vehicle or holes that may allow exhaust gases to enter the vehicle.

MIH 04.05.03 The interior of the vehicle, including all storage areas, must be kept clean in compliance with OSHA (or equivalent) standards, which is free of dirt, grease, and other biohazardous or noxious matter.

MIH 04.05.04 The vehicle must be cleaned as appropriate. All interior surfaces in the vehicle and medical equipment surfaces that come in contact with patients or patient body fluid (including respiratory aerosolization) must be immediately cleaned and disinfected or disposed of in a secure biohazard container.

MIH 04.05.05 The mechanic must have experience as a certified mechanic in a shop environment, or the maintenance must be done at a certified shop specific for the make and model of the vehicle.

MIH 04.05.06 The mechanic must be trained in infection control and educated on the dangers of unauthorized use of medical equipment, or a policy and practice must exist requiring the removal of

medical waste, regulated equipment, and regulated supplies, including non-over-the-counter medications, prior to vehicle servicing.

*** END ***