Submitted comments for Standards Changes from the 2nd Edition
Of the MIH Standards
Comments for the FIRST Draft
Committee responses are in red.

Date 02/13/2024 #1
Standard # - Suggested Change and Rationale for Change
No standard associated- Update safety culture survey that is sent to MIH programs to better reflect MIH.
The survey questions were updated to reflect MIH and a few questions that do not apply were deleted.

MIH 02.03.00, Page 2.5 Safety Management, Update to better reflect MIH

MIH 02.24.00, Page 2.9 Safety and Environment, Update to better reflect MIH

MIH 02.05.00, Page 2.9, Safety Education, Update to better reflect MIH

The MIH Standards Committee agreed to revisit all three of the above sections as one review. A subcommittee (C. Lennon, A. Williams, A. Ross, R. McClintock, R. Kink, MD) was established to rework, reword, combine, delete, and/or add to the sections to better reflect MIH. That work was completed and included the following sections from the 1st Edition (in gray). The changes are shown in red. Comments in blue are not part of the actual standards.

MIH 02.03.01 Safety Management ~~System~~ Program - Management is responsible for a Safety Management Program ~~System (SMS)~~ but both management and staff are responsible for ensuring safe operations. The Safety Management Program ~~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 or Safety Chairperson
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~~ process to track, trend, and mitigate errors or hazards
5. A ~~system~~ process to track and document incident root cause analysis
6. A MIH specific Safety Manual or MIH specific supplement to a larger 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~~ There is policy to identify and mitigate 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~~ The assessment can/may 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, as appropriate to the program (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.)

    d. General vehicle safety including:

        i. Loading/unloading equipment and supplies

        ii. Seat belt use

        iii. Securing loose items/equipment

    (was listed under safety education but now moved to required policies)

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

    a. Accountability – ~~employees are held accountable for their actions~~ with a clear process and root cause analysis.

    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~~ (moved below)

    ~~c. Professionalism – as evidenced by personal pride and contributions to the program's positive safety culture~~ (moved below)

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

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

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

12. A Safety Management ~~System~~ Program 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.~~

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

CAMTS new definition of "accident": **Accidents – An occurrence associated with the operation of an in service vehicle that takes place between the time any person boards the vehicle and until all such persons have disembarked, and which any person suffers death or serious injury, or in which the vehicle was substantially damaged. For surface vehicles, substantial damage is defined as any damage to the vehicle that takes it out of service, temporarily or permanently. This includes missions with a patient on board as well as missions that support the service's operations including service calls, maintenance, training, fueling, and marketing.**

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/or 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

5. A policy addresses the use of body cameras including when and how they will be used and how data will be stored, protected, and appropriately accessed.

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. Environmental ~~S~~survival training and equipment ~~is strongly encouraged~~ as appropriate to the geographic location of the program.

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~~
    (added these to the safety policy section above)

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 (as applicable)
    - 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

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MIH 01.06.00, Page 1.8, Management/Policies, Add continuity of operations planning

The committee agrees with the suggestion, but also noted that requirement for an Emergency Response Plan is outlined elsewhere and can be deleted from this section. The new wording will be:

MIH 01.06.01, 11. Management

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

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

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

c. Establishes continuity of operations planning

MIH 01.09.00, **Page 1.12 Meetings and Records**. Update to reflect remote/ virtual meetings/ record keeping of those types of meetings

The CAMTS Transport Standards Committee was asked the same questions and the MIH Committee agreed, for consistency, to use the same wording and response. We will work to use the same wording in both sets of standards. The committee response was:

The committee agrees to not change the standards. Meeting minutes are designed to be a summary of the key discussions, actions, and follow-up. Written documentation needs to include those in attendance, by name and title, discussions, actions and follow-up and loop closure, without having to sit through a video or audio copy. PowerPoint presentation may meet this standard if attendance is included, notes are added with content of discussions, decisions, action items, assignments, and follow-up.

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Date 02/16/2024 #2

Standard # - Suggested Change and Rationale for Change

MIH 01.09.01, Page 1.12 Meetings 1. There are formal, periodic staff meetings, for which minutes are kept on file. Suggestion - Could the meeting minutes be recorded and maintained in that format versus the traditional written meeting minutes model?

The CAMTS Transport Standards Committee was asked the same questions and the MIH Committee agreed, for consistency, to use the same wording and response. We will work to use the same wording in both sets of standards. The committee response was:

The committee agrees to not change the standards. Meeting minutes are designed to be a summary of the key discussions, actions, and follow-up. Written documentation needs to include those in attendance, by name and title, discussions, actions and follow-up and loop closure, without having to sit through a video or audio copy. PowerPoint presentation may meet this standard if attendance is included, notes are added with content of discussions, decisions, action items, assignments, and follow-up.

MIH 02.03.01, Page 2.6 - Safety Management Though there is not a specific standard for this, the Safety Culture Survey sent to the program needs to have MIH specific topics/language.

The survey questions were updated to reflect MIH and a few questions that do not apply were deleted. A copy of the survey will be shared with the committee.

MIH 03.02.04 1., Page 3.5 - Response Vehicles should include equipment as required by local, state, national, or medical director. Examples include but are not limited to... Add something here to address the use of private vehicles. Some MIH programs ask the clinician to drive their own vehicle to see the patient. Should there be requirements for age of the vehicle, minimum insurance and liability limits, etc. With all vehicles, develop standard as to when the patient can be transported, can clinician family members accompany a visit, can patient family members be transported with patient, etc.

The committee agrees with these recommendations and the discussion has led to several additional changes. We will add the following to MIH 03.01.04 and MIH 03.02.04

3. **A policy addresses how and when a patient and/or patient family member will be transported in a program owned or affiliated vehicle. (For example: to detox, mental health, physician office, etc.) The policy should also include the use of patient and staff safety equipment (i.e., back seat separation screen, video monitoring, etc.).**
4. **A policy addresses how and when non-employees may be transported in a program owned vehicle or in an in-service privately owned vehicle.**
5. **Programs using privately owned vehicles, to the extent possible, should meet all the requirements of the standards.**

MIH 03.03.02, Page 3.7 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. Does MIH require an EM boarded physician? Could other board specialties be accepted, such as Family Practice, Internal Medicine, etc. Why is current ACLS, PALS, etc. required. Could this requirement be waived if a program had written agreements with specialist and included the specialists in their quality, education, safety, etc. activities>

The committee agrees that the medical director should be appropriately trained and experienced pertinent to the program's scope of care. If the MIH medical director is also providing medical direction of the program's emergency

medical service (primarily applies to public safety) then they should be board certified in emergency medicine or in EMS. To provide better clarity the committee agreed to the following wording changes. This will also change Appendix B (Competencies by Personnel).

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, certificate # 2 is optional**~~

Supporting Education and Competency Criteria: Medical Director(s)

COMPENTENCY AREA 1: ~~**Emergency**~~ Medical Services

~~**1. Advance Cardiac Life Support (ACLS) according to the current standards of the American Health Association or approved equivalent**~~

~~**2. Pediatric Advance Life support (PALS) according to the current standards of the American Heart Association (AHA) or Advance 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)**~~

1. Certifications are required as pertinent to the program's scope of care and in accordance with state law

~~3.~~ 2. Vehicle and Equipment Operations (if relevant to scope)

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The committee also discussed the idea of creating a third category for "hospital at home". After discussion it was agreed not to make changes at this time. Government regulations are already well defined for hospital-at-home programs and regulation and legislation changes are currently under considerations. We will look at this again as part of the future editions if warranted.

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The above comments and committee reviews were as of August 26, 2024, and have been posted on the CAMTS website for public comments since that time. The following comments were reviewed at the July 11, 2025 committee meeting and need committee approval.

Date 02/06/2025 #3

Standard # - Suggested Change and Rationale for Change

MIH 01.01.03. Consider revising to "community needs assessment". Language used does not align with remainder of document (e.g., community needs assessment on page 32).

The committee agrees and will change the wording:

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

MIH 01.03.01. Consider addition of "emergency dispatchers" to the first responders listed. Dispatch plays a critical role in many 9-1-1 based MIH programs.

The committee agreed and will add "emergency dispatchers" to the list under item #4. Note that the list includes potential members to the stakeholder's users' group.

> This group may include (and not be limited to):
>
> 4. Public Safety – Police, Fire, **Emergency Dispatchers**, media

MIH 01.07.01. Revise to "QM (Quality Management)". QM is used first in this section, but is not defined until later sections (page 15).

The committee agreed and added both the name and initial to the first reference and added the initials after the title on section 02.01.00 Quality Management (QM)

MIH 03.03.02 . Consider revising to "medical director(s) should be board-certified in Emergency Medicine and preferably sub-specialty board certified in emergency medical services". This language aligns with the National Association of EMS Physicians (NAEMSP) most recent position statement.

The committee believes no changes are needed to the current wording.

Note from Dudley: After looking closer at the suggestions and the wording changes made in the CAMTS transport standards, I think this suggestion is reasonable. Anna agrees. In the first draft, which is posted on the website, we made the following changes as noted and approved in submission # 2 above. If the committee agrees, I showed the new changes in purple.

> 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**~~ **and preferably sub-specialty board certified** in 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, certificate # 2 is optional**~~
>
> Supporting Education and Competency Criteria: Medical Director(s)
>
> COMPENTENCY AREA 1: ~~**Emergency**~~ Medical Services
>
> ~~**4. Advance Cardiac Life Support (ACLS) according to the current standards of the American Health Association or approved equivalent**~~
>
> ~~**5. Pediatric Advance Life support (PALS) according to the current standards of the American Heart Association (AHA) or Advance 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)**~~

1. **Certifications are required as pertinent to the program's scope of care and in accordance with state law**

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

MIH 03.03.11 Consider revising to recognize academic contributions in addition to peer-reviewed publication, such as abstract submission/presentation at national conferences, oral presentation at national conferences.
The committee agrees and will add the following:

> **MIH 03.03.11** The medical director will encourage research into best practices and ~~contribute to published literature~~ **academic contributions in peer-reviewed publications, such as abstract submissions/presentations and oral presentations are national conferences.**

MIH 01.08.01.c. There are formatting issues in the PDF. The letter "c" is on the line above where it is intended. There are similar formatting issues on pages 12 and 19.
Thank you. We will try to find all incorrect numbering and lettering on the final printing.

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Date 05/12/2025 #4
Standard # - Suggested Change and Rationale for Change
03.01.03 - Currently has types of practitioners, documentation standards for each practitioner, electronic health record requirements and details, and licensure and certification information for practitioners all together.

Programs may have one or more of these elements in place, but not others. These should be split into separate standards so that appropriate assessment of each element can be stand alone.
The committee believes the MIH Standards and programs are too new to know and identify all possible practitioner types and the committee feels, at least for now, the wording is appropriate provided the program has policies and protocols and the personnel are licensed, certified, or permitted according to the AHJ. No changes will be made to the standard.

03.02.03 - Same comments for both Type I and Type II -
Currently has types of practitioners, documentation standards for each practitioner, electronic health record requirements and details, and licensure and certification information for practitioners all together.

Programs may have one or more of these elements in place, but not others. These should be split into separate standards so that appropriate assessment of each element can be stand alone.
The committee believes the MIH Standards and programs are too new to know and identify all possible practitioner types and the committee feels, at least for now, the wording is appropriate provided the program has policies and protocols and the personnel are licensed, certified, or permitted according to the AHJ. No changes will be made to the standard.

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Date 05/12/2025 #5
Standard # - Suggested Change and Rationale for Change
04.01.01 - 04.01.07: Specifically relevant to self-evaluation while going through the Accreditation process, each of these standards should remain separate in the standards and also separate for evaluation. This should apply for the program self-evaluation, as well as the prereviewer and site surveyor. The SCT and tools must be adapted to reflect this.

The committee agrees with this recommendation. This does not change the Standards however it will change the Standard Compliance Tool (SCT). The SCT will be updated after the 2nd Edition Standards are finalized.

04.01.07 and 04.03.01.

04.01.07 aligns more closely with **04.03.01** and should likely be reallocated to this section.

The committee agrees and we will make the following changes to 04.01.07 and 04.03.01:

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**~~

~~**2**~~**3.** Driving and operator records (speeding and other traffic violations) are reviewed by management minimally upon hire and then annually

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 **or for aborting a patient encounter if there is a safety concern**.

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Date 05/12/2025 #6

Standard # - Suggested Change and Rationale for Change

01.03.01 – Recommend modifying this to reflect a stakeholder group being encouraged, but it should not be necessary. For a private entity who offers EMS and MIH, community guidance and consultation for operations – either EMS or MIH – should not be mandatory and may not be required for delivering safe and effective patient care. This comment may also apply to **01.03.03**.

For Standard 01.03.01, the committee believes that a Stakeholders group is an important component to a strong MIH program. The make up of the group is up to the program and should be based on the program's patient base and scope of services. It could be as small as one or two representatives. The list in the standards includes groups that "may include" and are not required.

As for Standard 01.03.03, committee discussion lead to the following changes:

MIH 01.03.03 There is an annual report provided to the members of the stakeholder's users' group that **may** outline~~s~~ 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**~~**. Data should be driven by the needs of the stakeholders and the community served.**

01.02.00 – Financial Commitment. It may be worthwhile to consider adding a standard which encourages planning or evidence of commitment for seeking and maintaining program sustainability.

The committee agrees with the following wording change:

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. **Financial planning that seeks and maintains program sustainability is strongly encouraged.**

01.09.02 and throughout all standards. Review to remove the word Regiments and replace appropriately with regimens.

The program agrees and a word search found just one incident, which was corrected.

02.01.10 – Recommend separating out KPIs and thresholds for evaluation, and also separating Satisfaction Surveys to their own QM Standards. Presence or absence of these carry different implications than, for example, strong evidence that the improvement process chosen was also evaluated for effectiveness.

The committee agrees and will add a new Standard 02.01.15, modeled on the CAMTS transport standards:

02.01.15 Performance metrics, as identified by the program, must be multidisciplinary and reviewed at least quarterly (at a senior executive level). Based on the scope of care of the service, in addition to those marked "required", at least one performance metric from each the following groups, (with examples) is required to be tracked and trended on an annual basis.

1. Safety

a. Arrest during patient visit (i.e., CPR)

b. Exposure to infectious-disease patients realized during patient visit

c. Employee injury by type (caused by patient, sharps stick, vehicle crash, etc.)

d. Number of Never Events (see References) (required)

2. Operations

a. Fatigue risk management (such as use of time-outs, utilization of fatigue risk management tools)

b. Lights and sirens use (if installed in vehicles) (tracking is required along with one additional metric)

c. Service interruptions or delays

d. Diversion from original patient request to another request

e. Response to witnessed incident or an incident that was happened upon

f. Real-time feedback devices, event-recording cameras, speed governors and/or weather alert system reviews

3. Communications/Coordinator

a. ETA accuracy

b. Accuracy of patient service location

c Number of missed and aborted service calls

4. Business and Customer Service

a. Referred, subcontracted, or outsourced services

b. Negative feedback from requesting/receiving agents

c. Negative feedback from patients (tracking is required along with 1 additional metric)

5. Maintenance

a. Unscheduled maintenance rate

b. Missed/aborted service for maintenance (Volume required for PIF along with 1 additional metric)

Unsure of specific Standard – **Recommend addition of a standard** – perhaps general – which requires existing hospital, EMS, or fire policies to be adapted and/or applicable to expanded scope of service being provided by MIH/CP. For example, in Safety Management, are those being applied to MIH/CP? For example, in 01.06.02 – Employment Policies – will the requirements for background checks etc also apply to Type II practitioners or partners who work alongside the EMS employees as part of the MIH team? If those practitioners technically are employed by a separate entity, does this still apply? Has the policy been updated to reflect that decision?
The committee agrees that the standards would apply to those working as employees under the program but can no apply to those outside of that boundary as partners. However, if the MIH is the primary provider of service and inviting the partner agency to participate, the MIH program should consider making compliance with the CAMTS standards part of any agreement. If the MIH program is not be the host provider making this a requirement may be difficult.

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Date 05/12/2025 #7
Standard # - Suggested Change and Rationale for Change
03.03.12 – Currently the standard requires additional medical oversight by a physician. Consider modifying to reflect there being other providers (other than physicians) with the appropriate knowledge to ensure proper medical care and oversight.
The committee agrees and will change the wording as follows:

MIH 03.03.12 Medical Oversight

1. If the medical director is unavailable, there are other physicians, **Nurse Practitioners, Physician Assistants, or similar providers** (**who are acceptable by the AHJ and 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.

03.04.00 – Update training requirements specific to budgeting, grant writing and applications, etc to be required only if the program is grant funded or if grants are relevant to sustainability for the program.
The committee agrees and will make the following change:

MIH 03.04.01 Clinical Care Supervisor and MIH 03.04.02 Program Manager
Competency Area 4: general Operations
8. **If appropriate for the program**, knowledge of submitting grants, Requests for Proposals, Request for Application

DNR policy is in two places. Which of these is accurate? Should they be combined?
The committee agrees this is a duplicate and will delete 01.06.01 and renumber the standard:

~~**8. There is a policy that addresses DNR orders**~~

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Date 05/15/2025 #8

Standard # - Suggested Change and Rationale for Change

General - more EMS agencies, including those with MIH, are adopting body worn cameras. If an agency has elected to have BWC, a policy needs to exist which directs who from the team wears the BWC, how long footage is kept, etc

General - as agencies consider audio or video refusals, Policy should exist with guidance around use of this approach.

The following wording was proposed in the first draft of the 2nd Edition and was posted on the website as shown in gray below. The committee believes no additional changes are needed.

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/or 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

5. A policy addresses the use of body cameras including when and how they will be used and how data will be stored, protected, and appropriately accessed.

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Date 05/15/2025 #9

Standard # - Suggested Change and Rationale for Change

NEMSIS data standards are pending final approval and operationalization. It should be considered by the committee to include consideration of this as part of best practice for accredited programs. I.e. as available, reporting strongly encouraged to federal and state (i.e. NEMSIS, quality data initiatives)

The current standard already states:

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

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As of July 14, 2025