



The Commonwealth of Massachusetts  
Bureau of Healthcare Safety and Quality  
Office of Emergency Medical Services  
Mobile Integrated Health Program  
67 Forest Street, Marlborough, MA 01752

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Lieutenant Governor

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Commissioner  
Tel: 617-624-6000  
[www.mass.gov/dph](http://www.mass.gov/dph)

## **Application for Approval**

### **Mobile Integrated Health Care with ED Avoidance Component**

#### **INSTRUCTIONS**

This application form is to be completed by a health care entity applicant that is partnering with the applicable local jurisdiction(s)' designated primary ambulance service(s) that wishes to apply for a Certificate of Approval to operate a Mobile Integrated Health Care (MIH) Program with Emergency Department (ED) Avoidance component in Massachusetts. Please submit a completed Mobile Integrated Health Care (MIH) Program with Emergency Department Avoidance (EDA) application, or if the program already has an MIH Program approval (including responses relevant for ED Avoidance component), please submit a copy of the Certificate of Approval with this application. If seeking a Certificate of Approval for an MIH Program without an ED Avoidance component, please do not complete this application and instead complete the Mobile Integrated Health Care (MIH) Program application, and MIH Program application fee. If seeking approval for a Community EMS Program, please do not complete this application and instead complete the Community EMS Program application.

Unless indicated otherwise, all responses must be submitted in the format specified. Attachments should be labeled or marked so as to identify the question to which they relate.

MIH with EDA applicants must submit a non-refundable \$3,000 application fee along with their application. Once the application is reviewed and the applicant received their MIH Conditions Letter, the applicant must submit the MIH Program with EDA Application Remittance Form, and \$10,000 program registration fee in order for the program to be approved. Additional information about application requirements, fees, and the approval process, can be found in the application section of the MIH website at <https://www.mass.gov/how-to/apply-to-operate-an-mih-program-with-ed-avoidance>.

Pursuant to 105 CMR 173.030(A), the DPH will expedite review of applications with a focus on underserved populations, such as behavioral health patients.

## REVIEW

After a completed application and fee are received by the Department of Public Health (Department), the Department will review the information and will contact the applicant if clarifications or additional information for the submitted application materials are needed.

## REGULATIONS

For complete information regarding approval of an MIH with EDA Program, please refer to [105 CMR 173.000](#) and associated sub-regulatory guidance. It is the applicant's responsibility to ensure that all responses are consistent with the requirements of 105 CMR 173.000 and associated sub-regulatory guidance, and any requirements specified by the Department, as applicable.

## QUESTIONS

If additional information is needed regarding the MIH with ED Avoidance Component application process, please contact the MIH Program at 617-753-8124 or [MIH@mass.gov](mailto:MIH@mass.gov)

## APPLICATION ATTACHMENT CHECKLIST

- ☐ This application (MIH with ED Avoidance Component Application)
- ☐ If applicable, list of ESP partners and description of how program will address patients with behavioral health needs
- ☐ Affiliate hospital medical director(s') contact name, email address, and title
- ☐ Proposed Program Overview (2.a.)
- ☐ Gap in service delivery narrative (3.a.)
- ☐ Partnerships and Coordination of care description and documentation (4.a.)
- ☐ Organizational readiness description, organizational chart, and roles (5.a.)
- ☐ MIH Program Compliance and Capacity form (5.b.)
- ☐ Medical control and medical direction description, Medical Director biography, medical oversight plan (6.a.)
- ☐ 911 EMS systems coordination and service duplication description (7.a.)
- ☐ Policies and procedures (7.b.)
- ☐ Vehicle Attestation (7.c.)
- ☐ Clinical and triage protocols (8.a.)
- ☐ Training curriculum (8.b.)
- ☐ MIH with ED Avoidance Program application fee (\$2,000)
- ☐ Prior Approvals. If you have held MIH, MIH with EDA, and/or Community EMS approval, please include your previous approval number in the box on the below.  
Previous Application Number: \_\_\_\_\_

To submit this application and all required supporting documentation, please fax the documents to 617-887-8751 or mail to the Office of Emergency Medical Services, Mobile Integrated Health, 67 Forest Street, Marlborough, MA 01778

## 1. APPLICANT INFORMATION

\*Name of Applicant  
Organization  
(name by which you will  
conduct business):

\_\_\_\_\_

\*Address of Applicant  
Organization:

\_\_\_\_\_

\* Street \* City \* State \* Zip Code

\*Applicant Organization  
Contact Person:

\_\_\_\_\_

\*Title: \_\_\_\_\_

\* Email:

\_\_\_\_\_

\*Telephone Number:

\_\_\_\_\_

\*Name of Medical  
Director:

\_\_\_\_\_

\*Title: \_\_\_\_\_

\*Email Address:

\_\_\_\_\_

\*Telephone Number:

\_\_\_\_\_

\*Name of Ambulance  
Service:

\_\_\_\_\_

\*Ambulance Contact  
Person:

\_\_\_\_\_

\*Title: \_\_\_\_\_

\*Ambulance E-Mail  
Address:

\_\_\_\_\_

\*Ambulance Telephone  
Number:

\_\_\_\_\_

\*Name of Applicant  
Organization Authorized  
Signatory:

\_\_\_\_\_

\*Signature of Authorized  
Signatory:

\_\_\_\_\_

\* Date:

\_\_\_\_\_

Please refer to the instructions document on how to create an e-signature located at: <https://www.mass.gov/how-to/apply-to-operate-an-mih-program>

For each jurisdiction covered by the proposed program, the primary ambulance service must be included. Please include the following information for the ambulance service included in the proposed program. **Please attach a document including the contact name, email address, and title for each affiliate hospital medical director.**

|   |  |
|---|--|
| Primary Ambulance Service                     |  |
| Applicable Local Jurisdiction(s)              |  |
| Ambulance License Number                      |  |
| Ambulance Contact Name and Title              |  |
| Ambulance Telephone Number                    |  |
| Ambulance E-Mail Address                      |  |
| Total EMS Personnel FTEs in Proposed Program: |  |
| Paramedic FTEs in Proposed Program:           |  |

Please list all health care entities and associated contacts with which you have proposed operational partnerships: *Please include ambulance services, hospitals, health plans/insurers, physician practices/medical homes, and any other organizations*

If the proposed program intends to serve MassHealth beneficiaries with behavioral health needs, **please also attach** a description of how you will partner or coordinate with ESP(s) and list the ESP partners.

| Proposed Operational Partner | Contact Last Name,<br>First Name | Email Address |
|------------------------------|----------------------------------|---------------|
|                              |                                  |               |
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**Attestation:**

**In accordance with 105 CMR 173.000, the undersigned hereby applies for designation to establish a Mobile Integrated Health Care Program as set forth under provisions of 105 CMR 173.000.**

**The undersigned representative(s) of the applying organization hereby attest that, (1) the information provided in and submitted with this document is accurate and correct to the best of my knowledge; (2) the failure to file a complete and accurate application for approval or renewal may constitute grounds for denial or revocation of approval; and, (3) pursuant to the applying organization's responsibility as an approved Mobile Integrated Health Care Program to comply with 105 CMR 173.000, the applying organization acknowledges and understands the regulatory requirements of 105 CMR 173.000 and associated guidance documents, and is in compliance with the regulatory requirements of 105 CMR 173.000, and can provide verification of compliance upon request.**

\_\_\_\_\_  
Print Name of Authorized Signatory of Applicant  
Organization

\_\_\_\_\_  
Title of Authorized Signatory of Applicant  
Organization

\_\_\_\_\_  
Signature of Authorized Signatory of Applicant  
Organization

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Print Name of Medical Director

\_\_\_\_\_  
Title of Medical Director

\_\_\_\_\_  
Signature of Medical Director

\_\_\_\_\_  
Date Signed

## 2. PROPOSED PROGRAM OVERVIEW

- a. **Please attach** an executive summary which outlines a description of the proposed program, including 1. purpose and goals of the program, 2. key organizations and partners involved operationally in the proposed program, 3. patient population(s) and jurisdiction(s), 4. how this/these service(s) relate to the gap in service delivery narrative, and 5. the proposed ED Avoidance service(s) that would be provided.
- b. I attest that the program has documentation of appropriate clinical and triage protocols and advanced training for paramedics who will practice ED Avoidance programming.

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Signature of Authorized Signatory

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Date Signed

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Print Name of Authorized Signatory

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Title of Authorized Signatory

## 3. GAPS IN SERVICE DELIVERY

- a. **Please attach** a gap in service delivery narrative no longer than five pages per proposed service. The gap in service delivery narrative should use data, leverage a corresponding community health needs assessment, and be crafted in accordance with the Guidance for Preparing a Gap in Service Delivery Narrative.
- b. **Please check** which of the following improvements are addressed by each of your proposed service(s), and **list** the corresponding service(s) that apply for each improvement checked in the table below. The proposed service(s) should provide improvements in quality, access, and cost effectiveness, provide an increase in patient satisfaction, provide an increase in patients' quality of life, and provide an increase in interventions that promote health equity, including cultural and linguistic competencies.

*At least one box besides "Other" must be checked for each proposed service to qualify as complete.*

| Improvement  | Proposed service(s) that apply (Please list) |
|--|--|
| <input type="checkbox"/> A decrease in avoidable emergency department visits or hospital readmissions  |  |
| <input type="checkbox"/> A decrease in total medical expenditures  |  |
| <input type="checkbox"/> A decrease in cost to patient   |  |
| <input type="checkbox"/> A decrease in time to appropriate patient care in an appropriate health care setting  |  |
| <input type="checkbox"/> An increase in access to medical or follow-up care under the direction of the patient's Primary Care Provider   |  |
| <input type="checkbox"/> Improvement in clinical care coordination, including, but not limited to the patient's adherence to medication and other therapies previously prescribed by the patient's Primary Care Provider |  |
| <input type="checkbox"/> Other   |  |

#### 4. PARTNERSHIPS & COORDINATION OF CARE

- a. **Please attach** a description of how the proposed program will ensure coordination of care between partners, and **include documentation such as memoranda of understanding, letters of intent, or contracts** detailing any existing or proposed operational partnerships, contracts, agreements, affiliations, or formal relationships between the proposed program and any health care or related entities (i.e. ambulance services, hospitals, physicians practices, referral agencies, provider agencies, public health entities). If the proposed program does not intend to partner with other health care providers, please describe how the program will ensure coordination of care with an MIH patient's primary care provider, or if the patient does not have a primary care provider, with the patient's associated health care entity to establish a primary care relationship.

## 5. ORGANIZATIONAL READINESS

- a. **Please attach** a description of the proposed program's organizational readiness, including demonstrating that it has sufficient capacity to develop and operate the proposed program and to provide the proposed service(s). Sufficient capacity may be demonstrated through financial and legal viability information, and sustainability and compliance history. Please include an organizational chart specific to the applicant organization's management and operational structure in the field, and description of roles for the proposed MIH program.
- b. **Please attach** a completed MIH Program Compliance and Capacity Form.
- c. **Attestation:** I attest to the proposed MIH Program's organizational readiness and ability to meet appropriate standards regarding operations, location, personnel, equipment, and medical devices.

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\* Signature of Authorized Signatory of Applicant Organization

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\* Date Signed

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\* Print Name of Authorized Signatory of Applicant Organization

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\* Title of Authorized Signatory of Applicant Organization



## 6. MEDICAL OVERSIGHT

- a. Please attach a description of how the proposed program will provide access to qualified medical control and medical direction. In addition, please:
  - I. **Include** the Medical Director's biography,
  - II. **Include** the proposed program's plan for medical oversight, including lines of authority and responsibility, development and review of clinical protocols, training and assessment of skills, communication systems, and continuous quality assurance and improvement.
- b. I attest that the proposed MIH Program's designated Medical Director has complete medical oversight over all clinical aspects of the proposed program. I attest that the proposed MIH Program's Medical Director approves of the clinical protocols, and that the program has documentation addressing all relevant clinical protocols, training content, skill assessment processes, and a description of responsibilities of the medical director. I attest that the medical director shall have responsibilities that include but are not limited to:
  - I. Developing and updating clinical protocols appropriate to:
    - i. the unique medical needs of the MIH Program's patient population; and,
    - ii. the particular personnel providing MIH services, including, but not limited to, Community Paramedics, EMS Personnel, Nurses, Nurse Practitioners, Physician Assistants and others;
  - II. Granting authorization to practice to Community Paramedics and other EMS Personnel providing health care services on behalf of MIH Programs;
  - III. Ensuring that all MIH Program personnel are properly trained and provide health care services or treatment:
    - i. within the scope of their practice;
    - ii. in accordance with the clinical protocols developed for the MIH Program; and,
    - iii. in accordance with any additional training required by Department guidelines;
  - IV. Ensuring that the MIH Program maintains a secure and effective telecommunication system and that all online medical direction is recorded in a medical record;
  - V. Making online medical direction available to MIH Program personnel during all hours of operation;
  - VI. Ensuring that all physicians and other primary care providers who provide online medical direction to MIH Program personnel receive appropriate training in:
    - i. the scope of practice of each type of MIH Program personnel;

- ii. the specific clinical protocols developed for the MIH Program; and,
- iii. any additional training required by Department guidelines; and,

VII. Coordinating the MIH Program's continuous quality assurance and improvement program.

- c. Furthermore, I attest that policies and procedures include a process for obtaining a patient's informed consent at each clinical encounter and a process for coordinating care with a patient's primary care provider, or associated health care entity to establish a primary care relationship.
- d. Furthermore, I attest that the program will deploy a vehicle appropriate for the clinical encounter, and that all regulatory and manufacturer requirements specific to equipment, supplies and medications will be adhered to when responding to a MIH call or for a scheduled home visit.

|                               |  |             |
|-------------------------------|--|-------------|
|                               |  |             |
| Signature of Medical Director |  | Date Signed |

Print Name of Medical Director

Title of Medical Director

## 7. 911 TO MIH ED AVOIDANCE TRANSITION

- a. Please attach a description of how the proposed program will coordinate and manage the transfer of care from a 911 EMS patient to an MIH with EDA patient, including, in some cases, after consult with on-line medical direction, when the patient is determined by the primary ambulance service's paramedic to be a candidate for treatment at an alternate destination. The decision must be made in accordance with the Protocol for Determination to Treat/Transport to an Alternate Destination. The patient must provide written consent to be transported to an alternate destination, including acknowledgment that the patient will not be going to an Emergency Department. Please explain how the program will track, document, and perform continuous quality improvement on calls in which there is a transition from a 911 episode of care to a MIH treatment. Include an explanation on how your MIH with ED Avoidance Component Program will follow the process for timely coordination with a patient's primary care provider, or associated health care entity
- b. Please attach a copy of the proposed program's policies and procedures demonstrating how a patient's informed consent will be obtained. Policies and procedures must specifically outline how:
  - I. written refusal to transport will be obtained;

- II. written consent will be obtained for a patient to be treated as an MIH patient;
  - III. refusal and consent will occur after speaking with Medical Direction and in accordance with Mobile Integrated Health Program with an ED Avoidance Component Protocol for Determination to Treat/Transport to Alternate Destination.
- c. Please attach an attestation that the program will deploy a vehicle appropriate for the clinical encounter, and that all regulatory and manufacturer requirements specific to equipment, supplies and medications will be adhered to during a MIH with ED Avoidance Component encounter.

## **8. ATTACHMENTS**

- a. Please attach clinical and triage protocols that will be used as part of your proposed ED Avoidance service(s).
- b. Please attach a description of advanced training plans including the curriculum that will be utilized to train EMS Personnel who will support the proposed MIH Program with ED Avoidance component. Please include in the curriculum a description of how the competencies of trained resources will be demonstrated and assessed.