



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

MAURA T. HEALEY
Governor

KIMBERLEY DRISCOLL
Lieutenant Governor

KATHLEEN E. WALSH
Secretary

ROBERT GOLDSTEIN, MD, PhD
Commissioner

Tel: 617-624-6000
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 MIH Program application with this 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, the applicant must submit a separate MIH Program application, with all required attachments, responses, 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. Handwritten responses will not be accepted.

Attachments should be labeled or marked so as to identify the question to which they relate.

MIH applicants must submit a non-refundable application fee along with their application. Information on fee amounts as well as the MIH Program Application Remittance Forms, which must be submitted along with fee payments, 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 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

APPLICATION ATTACHMENT CHECKLIST

- ☐ Either (1) completed MIH Program Application or (2) Certificate of Approval for an already approved MIH Program. Note: The "Gap in service delivery narrative" in the MIH Program Application must be specific to the ED Avoidance Program.
MIH Program Application Number or Approval Number: _____
- ☐ 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
- ☐ Executive summary (2.a.)
- ☐ 911 to MIH ED Avoidance transition description (3.a.)
- ☐ Policies and procedures (3.b.)
- ☐ Clinical and triage protocols (4.a.)
- ☐ Training curriculum (4.b.)
- ☐ MIH with ED Avoidance Program application fee
- ☐ Application Resubmission. If this is a resubmission, please include your previous application number in the box on the below. Your application number or ID is provided on the last page of the previous application if it was saved
Previous Application Number: _____

To submit this application and all required supporting documentation, please fax the documents to 617-887-8751. Applicants must label all supporting documents with the 14-digit application ID found on the last page of the application.

1. APPLICANT INFORMATION

* Name of Applicant
Organization:

* Date: 01/05/2021

(name by which you will conduct business)

* Address of Applicant
Organization:

* Street

* City

* State

* Zip Code

* Name of Contact
Person:

* Title:

* Telephone Number:

* Email Address:

* Name of Medical Director:

* Title:

* Telephone Number:

* Name of Authorized

* Email Address:

Signatory:

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-with-ed-avoidance>

* Signature of Authorized

Signatory:

* Date:

* Program Funding: ☐ Agency funds ☐ Grant support ☐ 3rd party payers
☐ Tax revenue ☐ Other (describe):

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

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 | |

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*

| Proposed Operational Partner | Contact Last Name, 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 with ED Avoidance as set forth under provisions of 105 CMR 173.000.

The undersigned representative(s) of the provider 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 with ED Avoidance to comply with 105 CMR 173.000, the applying organization understands and acknowledges 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.

Signature of Authorized Signatory

Date Signed

Print Name of Authorized Signatory

Title of Authorized Signatory

Signature of Medical Director

Date Signed

Print Name of Medical Director

Title of Medical Director

2. PROPOSED ED AVOIDANCE SERVICES

a. **Please attach** an executive summary describing the ED Avoidance services that the proposed program intends to provide, including patient population(s) and jurisdiction(s), and how this/these service(s) relate to the MIH Program Application gap in service delivery narrative.

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.

Signature of Authorized Signatory

Date Signed

Print Name of Authorized Signatory

Title of Authorized Signatory

3. 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 to establish a primary care relationship.

- 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.

4. 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.

Document ready for submission

1. When the document is complete click on "Document is ready to submit". This will generate an application number, lock the responses, generate today's date and time-stamp the form.
2. Please keep a copy for your records by clicking on the "Save" button at the bottom of the page.

This document is ready to submit: ☐ Date:

Your Application Number:

Use this number on all communications regarding this application.

Save

Print

Reset

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