



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Office of Emergency Medical Services
67 Forest Street, Marlborough, MA 01752

Application for Approval Mobile Integrated Health Care

INSTRUCTIONS

This application form is to be completed by any health care entity that wishes to apply for a Certificate of Approval to operate a Mobile Integrated Health Care (MIH) Program for proposed services in Massachusetts. If seeking a Certificate of Approval for an MIH Program with Emergency Department (ED) Avoidance component, please do not complete this application and instead complete the MIH Program with Emergency Department (ED) Avoidance application. 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 it relates.

MIH applicants must submit a non-refundable \$1,000 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 Application Remittance Form and \$5,000 program fee in order for the program to be approved. Additional information about application requirements, fees, and the approval process, can be found on the MIH website at <https://www.mass.gov/how-to/apply-to-operate-an-mih-program>.

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 application process, please contact the MIH Program at 617-753-8124 or MIH@mass.gov.

APPLICATION ATTACHMENT CHECKLIST

- This application
- If applicable, list of ESP partners and description of how program will address patients with behavioral health needs.
- Executive Summary (2.a.)
- Gap in service delivery narrative (3.a.)
- Coordination of care and partnership description and documentation (4.a.)
- 911 EMS systems coordination and service duplication description (4.b.)
- 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.)
- Application Resubmission. If this is a resubmission, please include the date you originally submitted your application in the box on the below.
Date of Original Submission: _____

To submit this application and all required supporting documentation, please fax the documents to 617-887-8751, mail to the address at the top of the application, or email to mih@mass.gov. Applicants must label all supporting documents. 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>.

1. APPLICANT INFORMATION

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

Address of Applicant Organization: _____

Full Name of Contact Person: _____

Title: _____

Telephone Number: _____

Email: _____

Full name of Authorized Signatory: _____

Title: _____

Telephone Number: _____

Email: _____

Signature of Authorized Signatory: _____

Date of Signature: _____

Name of Ambulance Service: _____

Ambulance Contact Person: _____

Title: _____

Ambulance Telephone Number: _____

Ambulance Email Address: _____

Total EMS Personnel FTEs in Proposed Program: _____

Paramedic FTEs in Proposed Program: _____

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

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 attach** a description of how you will partner or coordinate with ESP(s) and **list** the ESP partners.

Proposed Operational Partner	Contact Last Name, First name	Contact Email Address

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.

* Signature of Authorized Signatory of Applicant Organization

* Date Signed

* Print Name of Authorized Signatory of Applicant Organization

* Title of Authorized Signatory of Applicant Organization

* Signature of Medical Director

* Date Signed

* Print Name of Medical Director

* Title of Medical Director

2. PROPOSED PROGRAM OVERVIEW

a. **Please attach** an executive summary which outlines a description of the proposed program, including purpose and goals of the program, key organizations and partners involved operationally in the proposed program, and the proposed service(s) that would be provided.

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.

b. **Please attach** a description of the proposed coordination and interaction with applicable 911 EMS systems in accordance with the provision of 105 CMR 170.000, including affirmation that the proposed program has policies and procedures that address the management of patients who experience a medical emergency and require activation of the 911 EMS system, and affirmation that if an MIH Program's on-scene personnel, after assessment and in accordance with medical direction, determines that the patient is experiencing a medical emergency, the MIH Program's on-scene personnel will activate the 911 EMS system and continue to assess and treat the patient in accordance with clinical protocols until transfer of care to the responding ambulance service in accordance with 105 CMR 170.355(B)(2) and (4), Department-established guidance, and the applicable service zone plan. Description should also include how the proposed program will deliver health care services without duplicating services.

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. I attest to the proposed MIH Program's organizational readiness and ability to meet appropriate standards regarding operations, location, personnel, equipment, and medical devices.

* Signature of Authorized Signatory of Applicant Organization

* Date Signed

* Print Name of Authorized Signatory of Applicant Organization

* 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