



CONNECTICUT
Public Health

CONNECTICUT MOBILE INTEGRATED HEALTHCARE BEST PRACTICES MANUAL

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Background**Overview:**

Healthcare systems in the United States have been impacted by increasing costs with variable quality output especially affecting the chronically ill population. Mobile Integrated Healthcare (MIH) offers an innovative approach to gaps in healthcare by providing quality care by synchronizing clinicians, infrastructure, and resources in a cost-effective manner.

Mission:

To provide a Mobile Integrated Healthcare system to the residents of Connecticut. The focus is designed to achieve in-home / patient-centered care, improve health accessibility and reduce emergency department utilization for non-emergent visits to increase positive health outcomes.

Vision statement:

To encourage collaboration between community partners in producing high quality, needs-based, holistic health assessments to the appropriate multidisciplinary care teams concerning the following, but not limited to:

- Chronic illnesses
- Social and behavioral health
- Medication compliance
- Prevention strategies
- Home safety

Notes on how this manual works:

Each section of the Connecticut General Statutes, Policies and Procedures follows the MIH program application process. For example, on the top half of page 6, there is “Sec. 19a-180b-2. Application and authorization procedures.” Below this section, there will be instructions for the following corporate information: (1) Business contact information, (2) Copy of applicant’s current license or certificate, and (3) List of vehicles to be used.

The samples in this document *Italicized in GREEN font* are meant to serve as examples and should not be used verbatim in an MIH application; each service's MIH application should reflect the specifics of their program and the collaboration process between the EMS organization, its partnering agency, medical director(s), and/or sponsor hospital.

The “Appendices” provide supplemental information that may help with community health assessments, public health framework and resources.

CT Department of Public Health Policies and Procedures Regarding MIH Programs:

Section 1. Until such time regulations are adopted in accordance with section 19a-177(6)(e) of the Connecticut General Statutes, the Commissioner of Public Health shall implement the following policies and procedures as regulation. These policies and procedures are implemented in accordance with section 19a-180(b) of the Connecticut General Statutes.

Sec. 19a-180b-1. Definitions

Sec. 19a-180b-2. Application and authorization procedures

Sec. 19a-180b-3. Mobile integrated health program standards

Sec. 19a-180b-4. Data collection and reporting

Sec. 19a-180b-5. Emergencies

Sec. 19a-180b-6. Prohibited Acts

The following hyperlink is provided to view the entire Operational Policy on the [Connecticut eRegulations System: Portal to Connecticut Regulations](#).

Sec. 19a-180b-1. Definitions:

1. “Attrition” means the loss of enrolled MIH patients to services for which they are enrolled other than through discharge in accord with the MIH program’s discharge criteria.
2. “Collaborating provider” means any hospital, health care provider or practice, or health care system, participating in a mobile integrated health care program approved pursuant to the Regulations of Connecticut State Agencies;
3. “Commissioner” means the Commissioner of the Department of Public Health or the commissioner’s designee;
4. “Department” means the Connecticut Department of Public Health;
5. “Emergency medical services organization” or “EMS organization” has the same meaning as section 19a-175 of the Connecticut General Statutes;
6. “Emergency medical services system” has the same meaning as section 19a-175 of the Connecticut General Statutes;
7. “Medical control” has the same meaning as section 19a-179-1 of the Regulations of Connecticut State Agencies;
8. “Medical direction” has the same meaning as section 19a-179-1 of the Regulations of Connecticut State Agencies. On-line medical direction means care provided under direct orders from the MIH physician. Off-line medical direction means care provided under standing orders;
9. “Mobile integrated health care program” or MIH program has the same meaning as section 19a-175 of the Connecticut General Statutes;
10. “Mobile integrated health care physician” or MIH physician means a physician licensed pursuant to Chapter 370 of the Connecticut General Statutes, who is authorized to provide medical advice and orders for treatment to MIH providers, as defined in this section, to a patient enrolled in an MIH program;
11. “Mobile integrated health care provider” or MIH provider means a paramedic licensed pursuant to Chapter 384d of the Connecticut General Statutes and authorized by the MIH physician pursuant to the Regulations of Connecticut State Agencies;
12. “Office of Emergency Medical Services” or OEMS means the office established within the Department of Public Health pursuant to section 19a-178 of the Connecticut General Statutes.
13. “Paramedic” means a person licensed pursuant to Chapter 384d of the Connecticut General Statutes;
14. “Patient hand-off report” means a verbal or written transfer of patient information and professional responsibility between providers;
15. “Personal delivery” means delivery directly to the intended recipient or a recipient’s designated representative and includes, but is not limited, delivery by electronic mail to an electronic mail address identified by the recipient as an acceptable means of communication; and
16. “Primary service area responder” or PSAR has the same meaning as set forth in section 19a-175 of the Connecticut General Statutes.

Section 1. Corporate Information

Sec. 19a-180b-2. Application and authorization procedures

- a) Pursuant to section 19a-180(b) of the Connecticut General Statutes, the Commissioner may authorize the addition of a mobile integrated health care program to an existing licensed or certified EMS organization. Each MIH program shall be authorized separately. No person or entity shall operate a MIH program without authorization from the Commissioner in accordance with this section.
- b) Application for authorization to operate an MIH program. Applications shall be submitted in a form and manner prescribed by the Commissioner, and shall include the following:
 - (1) Identification of current business contact information. The applicant shall provide contact information for the EMS organization, the chief executive officer, and the contact person completing the application.
 - (2) A copy of the applicant's current license or certificate as an EMS organization pursuant to Chapter 368d of the Connecticut General Statutes.
 - (3) List of vehicles to be used to provide proposed MIH services including license plate and vehicle registration.

This section should be filled out in its entirety:

1. Business Address – *Physical location of the organization e.g. 123 Main Street, Smithtown, CT 06000*
2. Mailing Address – *The address of the organization where it receives mail, it may be the same as #2 above or may be a PO Box, Mail Stop, etc. PO Box 123, Smithtown, CT 06000*
3. Telephone Numbers: If not applicable please use N/A
4. Chief Executive Officer – *The chief/president of the department. The designated leader of the service's operations. This person may or may not be the person in charge of the MIH program. Please use service related email, and phone numbers except where designated. John Smith, Chief, work 860-123-4567, home (203) 123-4567, cell (860) 891-0111 chief@smithtownems.org.*
5. MIH Contact - *The person filling out this application, who should be the person with overall responsibility for the MIH program for the service. This person may be the same as the person in #4 above. Please use service related email, and phone numbers except where designated. Jane Jones, MIH Director, work 860-123-4567, home (203) 123-4567, cell (860) 891-0111. MIH@smithtownems.org*

Section 1. Corporate Information

6. The applicant should submit a copy of their current license or certification as an EMS organization.
7. A list of vehicles that to be used in the provide the proposed MIH program, to include license plate numbers and VIN number of each.

Section 2: Needs Assessment / Gap Analysis

Sec. 19a-180b-2. Application and authorization procedures

(4.) Completed needs assessment.

(A.) The needs assessment shall identify and provide evidence demonstrating one or more healthcare needs which the proposed MIH program seeks to meet, or gaps in health care service delivery which the proposed MIH program seeks to address, or both.

(B.) The needs assessment shall identify the sources of data used to define the healthcare need or needs or service delivery gap or both.

Purpose: The needs assessment works together with a gap analysis. It is the process of collecting information about a community's assets, resource limitations, and/or access to healthcare to determine priorities. It is a review of the physical, mental, and social well-being of the community and how an MIH program can help facilitate gaps that exist in traditional healthcare systems by providing evidence of the unique community's population needs.

Needs Assessment

- A. Outlining a review of chronic health problems within a community can provide information on how to develop goals, set priorities and target community conditions that disproportionately impact people.
 - MIH can increase access to primary care services for people living in underserved areas, people with limited mobility, and those who can benefit from an increased level of care coordination.
- B. The needs assessment shall identify the sources of data collected to define the need for a MIH service. Examples of data resources utilized to gather information are from:
 - Local health departments
 - Hospital databases
 - Long-term care providers
 - Paramedic service databases
 - Medical providers
 - Community townhalls
- C. Examples of target patient populations:
 - Elderly or frail
 - People living with chronic conditions
 - Homebound patients

Section 2: Needs Assessment / Gap Analysis

- Frequent users of 9-1-1 with non-emergent needs
- Patients recently discharged from the hospital

D. Key terms to keep in mind concerning a needs assessment:

- Systemic causes: the fundamental causes of societal inequities that lead to poor health
- Social drivers of health: underlying social and economic conditions that influence people's ability to be healthy
- Social needs: individual's non-medical social or economic circumstances that hinder their ability and/or recover from illness

Refer to Appendix A for a Community Health Assessment Toolkit Guide

E. Present your assessment and identify any gaps in practice and room for improvement

- Provide a short report of your findings

Example: *“After reviewing discharge and admission information from Georgetown Hospital, Smithtown EMS has found that a significant number of CHF patients are re-admitted within 30 days of discharge because of a lack of follow-up with their PCP and use of maintenance medications.”*

Refer to Appendix B for Gap Analysis Examples

Refer to Appendix C for Information on Health Equity

Section 3: Letter of Intent and General Program Description

Sec. 19a-180b-2. Application and authorization procedures

(5.) A letter of intent including a general description of the proposed MIH program, which shall include the following:

(A.) Written proof of notification of the proposed MIH program issued to EMS organizations which shall include the relevant regional council and all PSARs serving any municipality where the applicant intends to operate the MIH program; and

(B.) Contingency planning to ensure continuity of service for MIH patients in the event of circumstances including but not limited to MIH program closure.

(C.) A description of the proposed MIH program which shall include, but not be limited to:

(i) Specific goals of care for the proposed services, meaning how the program will work to meet the needs or address gaps in service delivery as identified in the needs assessment; and

(ii) How the proposed program will define and evaluate program goals such as improvements in quality, access, and cost effectiveness;

(iii) An estimated number of patients the MIH program intends to serve annually

Letter of Intent Example: next page

Section 3: Letter of Intent and General Program Description

Connecticut Department of Public Health

Office of Emergency Medical Services

410 Capitol Ave, MS 12 EMS

Hartford, CT 06134

1 January 2025

Gentlemen:

Attached please find an application for the Smithtown EMS Department to be approved for an Mobile Integrated Healthcare (MIH) Program.

This program will be offered in collaboration with the Georgetown Hospital to follow-up on congestive heart failure (CHF) patients discharged from Georgetown Hospital. This program will focus on decreasing the number of patients who return to the hospital within 30 days by visiting them within 24 hours of discharge, reviewing their medication schedule, making sure the patients have access to their medications and understand the importance of remaining compliant with them. This will address the need that was found during our gap analysis that showed a high number of CHF patients being readmitted due to non-conformity with their medication regimen.

This program will use historical data gathered during the gap analysis as a base line for comparison to the group that receives the MIH care to show program effectiveness, costs, and quality of care. This information will be collated into a report format that will be submitted to the Department of Public Health (DPH) on an annual basis.

It is expected that in its first year this program will see 20 patients, and as the program continues we expect that additional patients will be added to the program with a potential maximum of 50 patients a year total.

Should the Smithtown EMS Department be unable to complete the visits on the scheduled day, they will be rescheduled for the following day. If there should be a program closure, the Georgetown Hospital will take responsibility for these patients as part of their community health program.

All notifications have been made, and the required supporting materials are attached as part of this application. Any questions about the application should be directed to Jane Jones the MIH Director for Smithtown EMS.

Yours sincerely,

John Smith, Chief Smithtown EMS Department

Section 4: Geographic Area to be Served

Sec. 19a-180b-2. Application and authorization procedures

(D.) A description of the geographic area to be served, which shall include, but not be limited to:

- (i) A map identifying proposed boundaries to the service area;
- (ii) A list of municipalities where the MIH program is proposing to provide services; and
- (iii) A list of PSARs who serve each municipality and EMS organizations with principal or branch locations in any such municipalities listed according to this section.

This section should be attached to the application with a separate title page, with the following format:

“Name of Service, MIH Application, Section 4 Geographic Area to be Served”

Example: *Smithtown EMS, MIH Application, Section 5 Geographic Area to be Served*

This section will be composed of two parts. The first will be a paragraph that describes the geographic area that will be served by the MIH Program. Remember that PSA assignments do NOT pertain to MIH programs. Refer to the section on notifications.

Examples:

The Smithtown EMS MIH Program will serve the town of Smithtown, which is bordered on the North by Massachusetts, on the South by Long Island Sound, on the East by Jonestown, and on the West by Blakesville.

Or

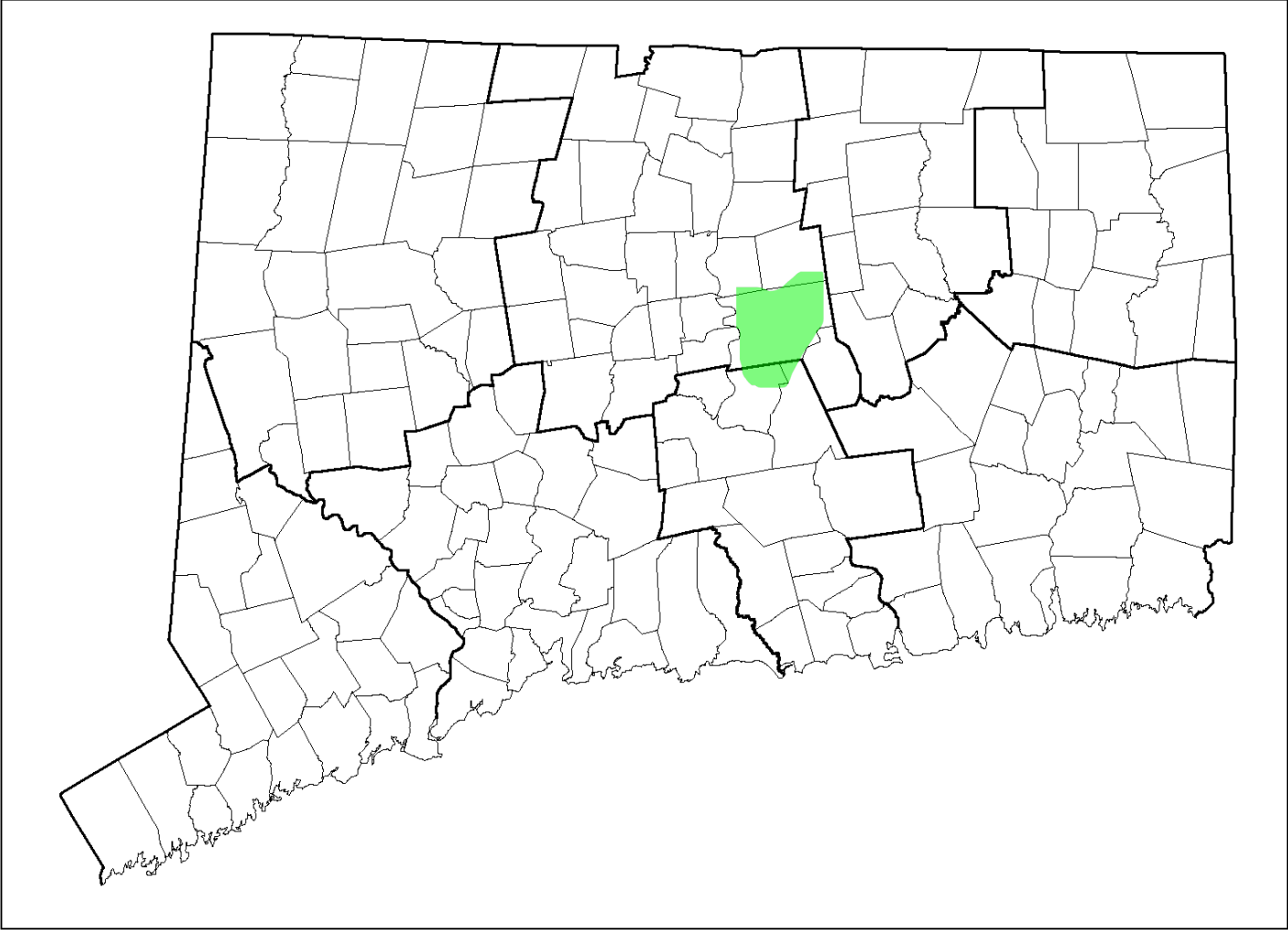
The Smithtown EMS MIH Program will serve the towns of Smithtown and Jonestown, bordered on the North by Massachusetts, on the South by Long Island Sound, on the East by Oldtown and on the West by Blakesville

Or

The Smithtown EMS MIH Program will serve the entire state of Connecticut. Bordered on the North by Massachusetts, the South by Long Island Sound, the East by Rhode Island, and the West by New York.

Section 4: Geographic Area to be Served

The second part will have a map of the proposed geographic area outlined/highlighted:



Ashley Smith

Map Source: CT Department of Economic and Community Development 1996

Figure 1.0 Map of Connecticut with a highlighted area of the proposed geographic area.

Section 5 : Patient Interaction Plan

Sec. 19a-180b-2. Application and authorization procedures

- (7.) A patient interaction plan, which shall include the following:
- (A.) Criteria determining patient eligibility to receive services from the MIH program;
 - (B.) Criteria determining how and when a patient may be discharged from the MIH program.
 - (C.) Patient informed consent;
 - (D.) Protocol and contact information for on-line medical direction;
 - (E.) Protocol and contact information for off-line medical direction;
 - (F.) How the MIH program will interface with the 911 system if an emergency arises, as set forth in section 19a-180b-5.

The patient interaction plan of your agency's MIH application will consist of 7 parts:

1. Include the process and contact information for on-line medical direction.
2. Include protocol and contact information for off-line medical direction.
3. Include patient informed consent and criteria determining patient eligibility for services from the MIH program.
4. Anticipated services to be administered to the MIH patient.
5. A list of the minimum medical equipment that will be needed to assess and treat the patient, in excess of that, listed in the Connecticut Statewide EMS Minimum Equipment list for First Responders.
 - a. To include equipment and treatments for immediate care of life-threatening conditions.
 - b. All MIH programs should provide the minimum equipment as listed for first responders in the Connecticut Statewide Minimum Equipment List.
6. Include criteria determining how and when a patient may be discharged from the MIH program;
7. How an emergency situation will be addressed should one come about during an MIH visit. Using the Emergency Situation Policy as guidance, include copies of relevant mutual aid agreements and applicable emergency care protocols.

(continued to page 15)

The purpose of these components is to demonstrate that your organization has taken into consideration the necessary components that come with operating a mobile integrated healthcare program. Your program's patient interaction plan may change and evolve based on lessons learned and the evolving needs of your organization, collaborating partner(s), community, and patients.

Smithtown EMS MIH Program

Patient Interaction Plan

Smithtown EMS' MIH Program will provide services to patients who are discharged from Georgetown Hospital with a diagnosis of Congestive Heart Failure.

Patients will be identified by the discharging physician for participation in the program and will ask the patient for consent to enter the program. Upon discharge, a referral will be made to the Smithtown EMS MIH program through the hospital social work office. Smithtown EMS will contact the patient, and arrange for the first visit, preferably within 24 hours of the patient arriving home. A home safety/health questionnaire check list should be completed prior to the visit (see appendix C).

During that first visit, patients will have the goals of their care presented, along with the objectives of the MIH program. Patients will then be asked to consent to continue in the program. Services provided will include: weight monitoring, medication compliance (to include education as to what medications the patient takes, the importance of taking them in a timely manner, and identifying and potential solutions to any barriers in obtaining or taking any medications), instructions on when to call the MIH program, their primary care physician, or cardiologist, and when to return to the hospital or dial 911.

The anticipated medical equipment for this program includes all the items on the Connecticut Statewide EMS Equipment list for First Responders, an AED, a scale to measure body weight, a computer or tablet with internet access, a 12 lead EKG.

Patients will be discharged upon the completion of four visits over a three-month period, or if the patient demonstrates compliance with objectives of MIH program and goals of their care, or upon request.

Should a medical emergency occur during the visit, Smithtown EMS MIH staff will begin care as a first responder. The local PSAR holder will be notified by calling 911 or via radio and proper handoff of the patient to the emergency responder will happen. Emergency care will be governed by the Connecticut Statewide EMS Protocols, which includes both online and offline medical direction.

Refer to Appendix D for Safety Assessment and Health Questionnaire

Section 6: Staffing Plan

Sec. 19a-180b-2. Application and authorization procedures

(8.) Documentation of staffing, which shall include, but not be limited to, the following:

- (A) Roster and resumes of all professional staff planning to provide services through the proposed MIH program; and
- (B) A letter of authorization to practice as an MIH provider by medical control for each paramedic intending to provide MIH clinical care.

Purpose: To properly document a staffing plan of a proposed MIH program according to what services will be provided. The level of care being applied for will determine the staffing and educational needs of the MIH program.

(A) Include a roster with subsequent resumes for each professional staff member, including individual copies of MIH medical control authorization letters

1. Create an organizational chart to identify staffing responsibilities:

- Medical Directors
- Supervisory Staff
- Caregivers
- QA Review / Coordinator
- Scheduling Coordinator
- Supply Management
- Training and Education Coordinator
- Information Technology
- Communication: dispatch/telehealth

2. Staffing needs should be based on the following:

- Case load demands to accommodate time commitments
- Incorporate a plan to flex staff with patient growth/ census drop
- Scheduling coordinator to manage Pts efficiently

Section 6: Staffing Plan

2. Training and education priorities:
 - Depends on the level of care provided
 - Determine if training is paid on shift or off shift
 - Consider non-emergent situational training: initial/ refresher

4. Operational considerations for patient service delivery:
 - Supply chain management: sourcing, design, software
 - Ensure products are available
 - Promote safety compliance

Section 7: Education Plan

Sec. 19a-180b-2. Application and authorization procedures

- (6) An educational plan, which shall include, but not be limited to, the following:
- (A.) Education and training requirements which shall be established cooperatively between the EMS organization, the EMS medical director, the MIH physician, or both;
 - (B.) How the plan satisfies the specific goals of care for the proposed services within the MIH program;
 - (C.) A description of training for both initial and ongoing training of MIH providers, which shall include, but not be limited to, the following:
 - (i) Goals and objectives of the training program;
 - (ii) A description of any required clinical training;
 - (iii) A description of how didactic and clinical education will be recorded; and
 - (iv) A description of how course completion will be documented and required competencies will be measured.
 - (D) A signed agreement, between the EMS organization and the EMS organization's medical director, and the MIH physician if separate, addressing the educational plan. Such agreement shall be renewed biennially with the renewal of the MIH program authorization. Such agreement shall include, but not be limited to, the following components of the educational plan:
 - (i) A description of the proposed MIH program identifying the services planned;
 - (ii) An overview of the content and administration of the proposed MIH program training;
 - (iii) Identification of personnel and clinical locations for the proposed MIH program training;
 - (iv) The role of the medical director or medical directors in the proposed MIH training program;
 - (v) Identification of personnel responsible for medical content of the proposed MIH training program; and
 - (vi) Identification of personnel responsible for the documentation requirements in subparagraph (C) of this section.

Section 7: Education Plan

Purpose: The goal of this document is to provide guidance on educational best practices to agencies planning to implement an MIH program. Additionally, this document will aid in completing Section 8 of the MIH application.

Overview: Every MIH program's educational needs will be different, based on what their community requires. With this understanding it is recommended that MIH educational programs contain distinct sections.

Background: Educational requirements for MIH programs across the United States are varied. There are 300- hour programs, such as the widely accepted National consensus program from Minnesota versus many other states which allow for program topic specific training that may only be 70-100 hours. (NASEMSO 2018 CP-MIH Status Board Report)

Section 1: Core Content

An MIH paramedic must have an understanding of core concepts of MIH (see below) in order to understand how their role and program fits into their community. In order to accomplish this, all MIH paramedics should have education in the following areas:

- History of MIH/Community Paramedicine
- Role of MIH
- Ethical Considerations
- Safety Considerations
- Legal Considerations
- Needs Assessment
- Social Determinants of Health
- Preventative Care
- Chronic Diseases
- Lab Values Review

Section 7: Education Plan

Section 2: Program Specific Content (Didactic)

This section is dependent on what the specific goal of the MIH program is. For example, if a program is focused on prevention re-admission for CHF patients, the paramedic should have additional training on CHF from an individual who specializes in that area. The content in this section must follow the guidelines presented in

Sec. 19a-180b-2. Application and authorization procedures, part 6, section C.

A description of training for both initial and ongoing training of MIH providers, which shall include, but not be limited to, the following:

- (i) Goals and objectives of the training program;*
- (ii) A description of any required clinical training;*
- (iii) A description of how didactic and clinical education will be recorded; and*
- (iv) A description of how course completion will be documented and required competencies will be measured.*

Section 3: Clinical Expectations

In order to effectively operate as an MIH Paramedic there is an expectation that the paramedic will participate in clinical rotations that are specific to their MIH program.

- Clinical expectations should be developed in conjunction with: EMS organization's medical director and (if separate) the MIH physician.
- Clinical expectations should include the following:
- Minimum competencies for any skills required (i.e. obtaining labs, EKG evaluation, lab evaluation)
- Minimum competencies for use of any new or specialized equipment
- Minimum competencies for documentation
- Identified affective domain competencies

Section 7: Education Plan

Section 4: Education Completion

A MIH educational program should have a clear path that identifies what “successful” completion of the training entails. **Examples of this may include the following:**

- Written exam developed by program
- Certification by passing ISBC exam
- Clinical competency portfolio

Section 5: Continuing Education/Remediation

All levels of EMS clinicians are expected to complete continuing education, a MIH provider should be no different. A continuing education plan should include the following:

- Recommendation for hours/competencies required during a specific time period
- Identification of QA requirements that will guide continuing education
- Identification of pathways for remediation if necessary

Section 6: Instructor Qualifications

There is no specific training or certification to become an instructor for a MIH program. It is recommended that instructors for an MIH program have the following:

- Knowledge of the core content goals/objectives
- Relative/appropriate subject matter expert, education/experience related to MIH program’s focus
- Previous experience teaching
- As approved by EMS medical director and/or MIH physician

Section 8: Medical Direction

Sec. 19a-180b-2. Application and authorization procedures

(9) A medical direction and quality improvement plan, which shall include, but not be limited to, the following:

(A) A signed MIH medical control provider agreement between the applicant EMS organization and their sponsor hospital in a form and manner prescribed by the department;

(B) A non-exclusive list of providers to whom patients enrolled in a specific service offered by the MIH program may be referred;

(C) Protocols and contact information for on-line medical direction;

(D) Protocols and contact information for off-line medical direction;

A quality improvement and assurance plan, which shall include, but not be limited to, the following:

(i) A description of routine review of patient care for all MIH patients;

(ii) A description of review procedures for instances of deviation from protocol or deviation from a patient care plan;

(iii) A description of remediation procedures for instances of deviation from protocol or deviation from a patient care plan; and

(iv) A description of the roles of the medical director in the implementation of the quality improvement and assurance plan.

Section 8: Medical Direction

This section should be attached to the application with a separate title page, with this format:

“Name of Service, MIH Application, Section 8 Medical Direction.”

Example: *Smithtown EMS, MIH Application, Section 8 Medical Direction*

In this section, the applicant should describe their medical direction process. The medical director for the MIH program will be the EMS services’ medical director and it may also include a physician apart from the EMS Services’ Medical Director with expertise in the specialty area specific to the MIH program.

Any medical director involved with a MIH program shall be licensed as a physician pursuant to Chap 370 of the Connecticut General Statutes and have appropriate understanding and experience relevant to the services provided by the MIH program. If separate from the EMS medical director, the two shall collaborate to ensure that the appropriate training, education, qualifications, and scope of practice are maintained for all EMS clinicians providing services as part of the MIH program.

The medical director(s) have a variety of responsibilities as part of the MIH program. Please include detail regarding how each of these responsibilities will be ensured:

- A description of how medical oversight will play into accomplishing the goals of the MIH program as previously detailed (refer to section 3).
- Withholding medical direction authorization from individual EMS clinicians
- Delegating authority for direct medical oversight (DMO) to qualified physicians as appropriate for the care of patients served by the MIH program.
- Creating a Medical Direction and Quality Improvement Plan which includes, but is not limited to the following components:
 - A signed MIH medical control provider agreement between the EMS organization and their sponsor hospital / MIH medical director
 - A description of the roles of the medical director(s) in the implementation of the Medical Direction and Quality Improvement Plan.
 - A list of paramedics that are authorized to provide MIH services
 - Protocols pertinent to the MIH program
 - Protocol for contacting DMO
 - A quality improvement and assurance plan, which shall include, but not limited to the following:
 - A description of the monthly review procedure for instances of deviation from protocol, patient interaction plan (previously cited in part XXX) or other issues of concern. The process should be inclusive of both the MIH medical director and the chief executive officer of the MIH program.
 - A description of remediation procedures for concerns identified.

Attestation that the medical director(s) acknowledge their role in the MIH Educational Plan

(see section 7)

Section 8 Medical Direction

Example: *Smithtown EMS MIH Program Medical Direction and Quality Improvement Plan*

The Smithtown EMS MIH Program has Dr. John Jones as its MIH medical director and Dr. Jane Smith as its EMS medical director. Dr. Jones and Smith have been working collaboratively with Smithtown EMS to produce our MIH program and have signed the attached medical direction agreement with Smithtown EMS, and our Sponsor Hospital (Georgetown Hospital). Dr. Jones is a board-certified Cardiologist with experience and expertise in Congestive Heart Failure and is an attending physician at Georgetown Hospital. Their resumes are attached.

Dr. Jones and Smith have reviewed and provided guidance and input on our Educational Plan and have approved it, as is verified by their signatures on the educational plan agreement. They regularly participate in reviews of the educational content and have taught in various aspects of the training program. Dr. Jones is responsible for medical content of our MIH education, with day-to-day training being completed by our department educator Susan Sharpe.

Dr. Jones will also be responsible for educating the physicians of the Georgetown Specialty Group who may provide online medical direction or telehealth services to MIH paramedics and patients. A list of physicians who are trained and delegated medical direction authority from the Georgetown Specialty Group is attached.

We have established a Quality Improvement/Quality Assurance program for our MIH program that will meet monthly. The committee consists of Dr. Jones, Dr. Smith, John Smith, our EMS service chief, Jane Jones our MIH Coordinator, as well as our department educator Susan Sharpe, and Georgetown Hospital EMS Coordinator Sam Goodwin.

The committee is responsible for meeting monthly to review MIH calls, review best practices, and make recommendations for remediation as needed. The committee will look at all MIH calls/a percentage of MIH calls/a random selection of MIH calls at each meeting.

Deviations from protocol or the patient interaction plan that are identified will be assigned to Susan Sharpe to review with the paramedic(s) involved. Remediation may include any of the following: Review of proper procedure, demonstration of proper procedure, ongoing review of the paramedic's MIH calls, suspension from practice as an MIH provider, or withdrawal of medical control authorization as an MIH provider as deemed necessary by the committee.

Letters of medical control authorization will be issued at the completion of the education as outlined in our educational plan (including any precepting) by Dr. Jones and Smith jointly and will generally be done through EMS Coordinator Sam Goodwin's office at Georgetown Hospital. A roster of those paramedics authorized as MIH providers will be jointly maintained by Georgetown Hospital and Smithtown EMS and is attached.

Jane Jones, the MIH Coordinator at Smithtown EMS, is responsible for all record keeping requirements for the Smithtown EMS MIH program.

A copy of our online/offline patient care protocols are attached.

Section 9: Data Collection Plan

Sec. 19a-180b-2. Application and authorization procedures

(10) A data collection plan which shall include, but not be limited to, the following:

- (A) How patient information will be collected and stored;
- (B) How patient information including charts for clinical visits will be shared with collaborating providers, as applicable;
- (C) How MIH call records will be submitted to the Department as required under Connecticut General Statutes section 19a-177(8); and
- (D) How data will be collected and evaluated to ensure quality and measure outcomes as defined in the program goals identified in subdivision (5) of this section.

Purpose

Mobile Integrated Healthcare (MIH) programs typically document patient encounters and collect relevant data using a robust electronic medical record (EMR) system (i.e., Epic, Oracle Health, Meditech, etc.). These systems enable longitudinal documentation of each patient encounter across the healthcare continuum and facilitate multidisciplinary collaboration between the MIH clinician, MIH program, and the patient's established care team. Their use by EMS organizations engaging in MIH should be considered a best practice. It is recommended that EMS agencies who do not have access to a robust electronic medical record system, identify potential stakeholders or collaborators to align with, whereby they can receive access to an electronic medical record system to document their MIH encounters.

Some MIH programs may document patient encounters solely within their existing electronic patient care record (ePCR) system.

CT OEMS shall receive a copy of the patient care report, and the documentation must be sent and/or recorded in the collaborating partners EMR system. If the patient is admitted to the hospital or is receiving ongoing care, this needs to be clearly documented.

Section 10: Letters of Support from Collaborating Agencies

Sec. 19a-180b-2. Application and authorization procedures

(11) Letter or letters of support. The applicant may submit letters of support from additional agencies or entities.

This section should be attached to the application with a separate title page, with this format:

“Name of Service, MIH Application, Section 10 Letter(s) of Support from Collaborating Agencies)”

Example: *Smithtown EMS, MIH Application, Section 11 Letters of Support from Collaborating Agencies.*

The collaborating or partnering organization(s) identified in Section 3 of the application should write a letter of support to the Office of Emergency Medical Services, affirming their participation in the MIH program, and outlining their role and the responsibilities that are part of that role. This will depend upon the exact MIH program offered.

If there are multiple collaborating agencies, then a letter should be attached from each one.

There is an example on the following page.

Section 10: Letters of Support from Collaborating Agencies

Example:

Department of Public Health

Office of Emergency Medical Services

410 Capitol Avenue, MS #12EMS

P.O. Box 340308

Hartford, CT 06134-0308

Date

Gentlemen;

The Georgetown Hospital is pleased to support the application of Smithtown EMS' MIH program. This will be a collaboration between our two agencies, with Smithtown EMS providing EMS clinicians to perform follow-up on our discharged CHF patients (or other description of the MIH program).

Our hospital will be providing medical direction through Dr. John Jones, our director of Cardiology, partnered with our EMS Medical Director Dr. Jane Smith. Drs Smith and Jones will be an integral part of establishing the training program for the Smithtown paramedics, as well as take part in the monthly Quality Assurance process of the MIH program. (or other description of collaborating partner's role).

We look forward to putting our program into operation upon approval of the Department of Public Health.

Yours sincerely,

Georgetown Hospital

Section 11: List of EMS Organizations Notified and Proof of Notification

Sec. 19a-180b-2 (D)(iii). Application and authorization procedures

(D) A description of the geographic area to be served, which shall include, but not be limited to:

(iii) A list of PSARs who serve each municipality and EMS organizations with principal or branch locations in any such municipalities listed according to this section.

This section should be attached to the application with a separate title page, with this format:

“Name of Service, MIH Application, Section 12 List of EMS Organizations Notified and Proof of Notification.

Example: *Smithtown EMS, MIH Application, Section 12 List of EMS Organizations Notified and Proof of Notification.*

This section of the application will be broken down into two parts.

The first part will be list of EMS Organizations that need to be notified that your EMS service is submitting an application for an MIH program. It should include all PSA holders, the local EMS Regional Council, and any EMS organizations that have a principal or branch location in the geographic area that you intend to operate. A list of PSA holders can be found by going to www.elicense.ct.gov

- In the upper right-hand corner, click under “online services” menu.
- On the following page click on the “Emergency Medical Services” drop down,
- and then check the report titled “Primary Service Area by EMS Service (No Fee Required)”
- Click “Continue” on the bottom of the page.
- Choose the format that you want the report in.
- Use this list to determine which EMS organizations need to be notified.

Section 11: List of EMS Organizations Notified and Proof of Notification

Notification will include a short description of the proposed MIH program, and the contact information for the MIH physician, the EMS Medical Director, the Collaborating Organization, and the EMS Organization.

Example of notification:

Smithtown EMS is applying to the Office of Emergency Medical Services for an MIH Program.

This MIH program will address (type of patients the MIH program will address) and cover the following geographic area (describe the geographic area that the MIH program will serve). Our

medical direction for this program will be from Dr. John Jones, and Dr. Jane Smith of

Georgetown Hospital. You may contact the MIH medical director at

Dr.John.Jones@georgetownhosp.org and our EMS medical director at

Dr.Jane.Smith@georgetownhosp.org. Our collaborating partner is the Georgetown Hospital,

The second part of this section shall include evidence of notification:

- This can be in the form of copies of either returned receipts from the US Postal Service or electronic mail acknowledging receipt of the notification from a representative of the notified EMS Organization.

Section 12 Payment and Funding Structure

Sec. 19a-180b-2. Application and authorization procedures

(12) Evidence of payment structure. The applicant shall submit a funding plan for both startup costs and ongoing costs. Such plan shall include how the proposed MIH program will receive payment for services

This section should be attached to the application with a separate title page, with this format:

“Name of Service, MIH Application, Section 12 Payment and Funding Structure

Example: *Smithtown EMS, MIH Application, Section 12 Payment and Funding Structure*

The purpose of this section is to show financial viability for the MIH program. The applicant should have a plan to pay for startup and ongoing expenses.

There are a variety of methods to meet this requirement and to obtain funding. Grants from various sources, payment from collaborating agencies, and internal EMS organization funds are all potential options for accounting for these costs. Evidence that could be submitted with the application would include things like a grant award letter, a bank account statement, or an agreement between the collaborating agency and the EMS organization that describes the source of the funds.

After identifying the source of funding for the MIH program, the applicant should then submit an explanation as to how the EMS organization will be paid for its services. Examples could include a flat rate paid for all patients, or a per patient basis; or that the EMS organization submits an invoice to the grant funder or collaborating organization, etc.

A best practice would be to include an estimated budget of costs and show how the funding available will be enough to cover those expenses, and then explaining how the EMS organization is paid and the process for receiving those funds (as applicable).

Section 13 Certificate of Insurance Forms

Sec. 19a-180b-2. Application and authorization procedures

(13) Current certificates of insurance for general and professional liability insurance, automotive insurance coverage pursuant to section 19a-180-2(d) of the Regulations of Connecticut State Agencies, and workers compensation insurance

This section should be attached to the application with a separate title page, with this format:

“*Name of Service, MIH Application, Section 14 Certificate of Insurance Forms.*”

Example: *Smithtown EMS, MIH Application, Section 14 Certificate of Insurance Forms*

This section of the application should include insurance binder(s) or certificate(s) that show the name of the insurance company, the name of the insured EMS Organization, and dollar amounts that meet or exceed those that are listed in 19a-180(a) of the Connecticut General Statutes, namely:

Until such regulations are adopted, the following shall be the required limits for licensure:

(1) For damages by reason of personal injury to, or the death of, one person on account of any accident, at least five hundred thousand dollars, and more than one person on account of any accident, at least one million dollars,

(2) for damage to property at least fifty thousand dollars, and

(3) for malpractice in the care of one passenger at least two hundred fifty thousand dollars, and for more than one passenger at least five hundred thousand dollars.

In lieu of the limits set forth in subdivisions (1) to (3), inclusive, of this subsection, a single limit of liability shall be allowed as follows:

(A) For damages by reason of personal injury to, or death of, one or more persons and damage to property, at least one million dollars; and

(B) for malpractice in the care of one or more passengers, at least five hundred thousand dollars.

Applicants are advised that these amounts are statutory minimums and date from 1986, and they are encouraged to speak with their insurance provider to determine appropriate levels of insurance that meet this requirement.

In addition to the above, applicants are also required to submit copies of their worker’s compensation, and automotive insurance certificates of coverage (if applicable).

Section 14 Other Information

Sec. 19a-180b-2. Application and authorization procedures

(14) Any other information required by the department.

This section should be attached to the application with a separate title page, with this format:

“Name of Service, MIH Application, Section 14 Other Information.

Example: *Smithtown EMS, MIH Application, Section 14 Other Information*

This section of the application allows the applicant to submit any additional information that they deem helpful and supportive of their application. Examples include:

- Letters of support from elected officials, other healthcare professionals, etc.
- Material or information not requested but that the applicant deems important to submit
- Any other information requested by the Department

Appendices:

Appendix A: Community Health Assessment (CHA) Toolkit

American Hospital Association (AHA) has a nine-step comprehensive guide for health systems to collaborate with their communities and strategic partners to conduct a CHA. Follow this hyperlink to review the [Community Assessment Toolkit](https://www.healthycommunities.org/resources/community-health-assessment-toolkit).

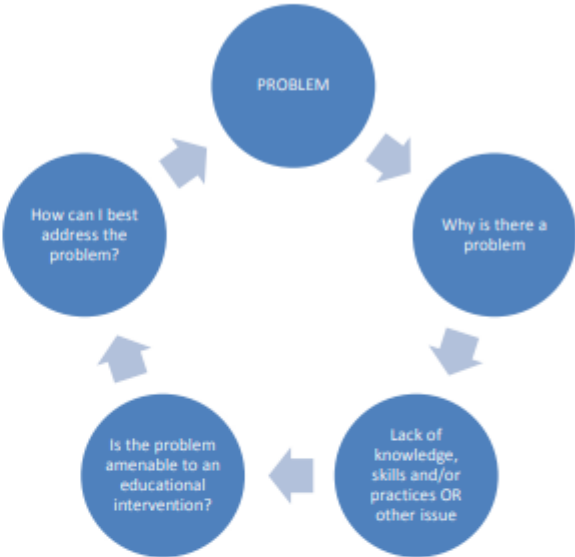


Figure 2.0 AHA Community health improvement nine step guide. 2024.
<https://www.healthycommunities.org/resources/community-health-assessment-toolkit>

Appendix B: Gap Analysis Examples

Gap Analysis

A *Gap Analysis* is similar to a *Needs Assessment*, but it allows for a more standardized process of determining what the gap-in-knowledge (or need) is. It is important to perform a Gap Analysis to justify the necessity for the educational activity and to guide you to select the appropriate teaching and evaluation methods. Ultimately, this is the justification for why you are putting on this activity.



Gap Analysis: The method of identifying the difference between current knowledge, skills, and/or practices and the desired best practice (or the Desired State).

Needs Assessment: The process of collecting and analyzing information that can influence the decision to initiate a new program or revise an existing one.

Professional Practice Gap: The problem in practice or the opportunity for improvement.

Steps to conducting a Gap Analysis: (see page 3 for examples)

Current State	Desired State	Identified Gap	Gap due to knowledge, skill and/or practice	Methods used to Identify Professional Practice Gap
What is currently happening?	What should be happening?	Difference between what is and what should be.	Why do you think the current state exists? What is the underlying or root cause?	What evidence do you have to validate the gap exists?

Fig 3.0 UCLA Health: Course Planning Tip Sheet. 2016.

<https://www.uclahealth.org/sites/default/files/documents/ce-GapAnalysis-052016.pdf>

Approach community members with appropriate health communication. This includes the following concepts:

- Use appropriate terms for select population groups; not all members of your priority audience will have health literacy; be aware of language barriers
- Successful community engagement builds trust; avoid implying that a person or population are responsible for increased risk of adverse health outcomes
- Look for ways to develop more inclusive health; be mindful of cultural differences
- Incorporate a patient-centered care approach with empathy

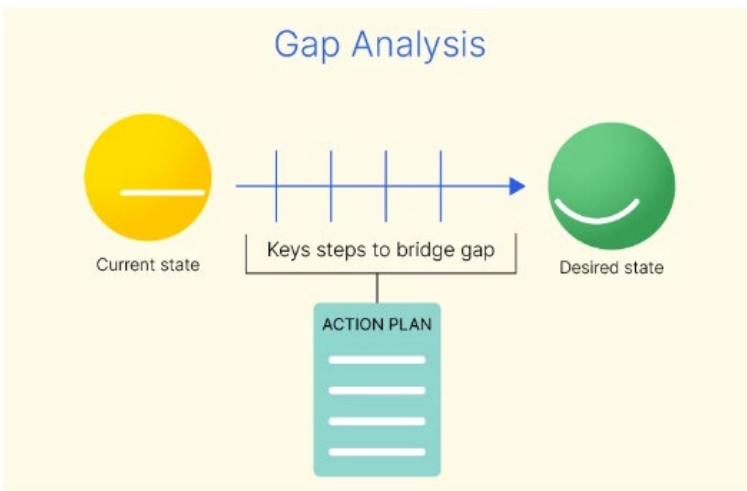


Figure 4.0 Gap analysis diagram. 2024. <https://www.voxco.com/blog/gap-analysis-in-healthcare/>

Examples of gaps in healthcare:

- A patient with a family history of diabetes does not get a regular checkup of insulin levels
- A patient ignores the recommended prescription drugs schedule for his illness and has history of fall incidents; does not realize if the 2 situations are related
- A diabetic lives in a rural location and does not have access to transportation therefore does not receive appropriate wound care for an open sore on his foot

The following diagram is a flowchart to approach effective communication within a community:

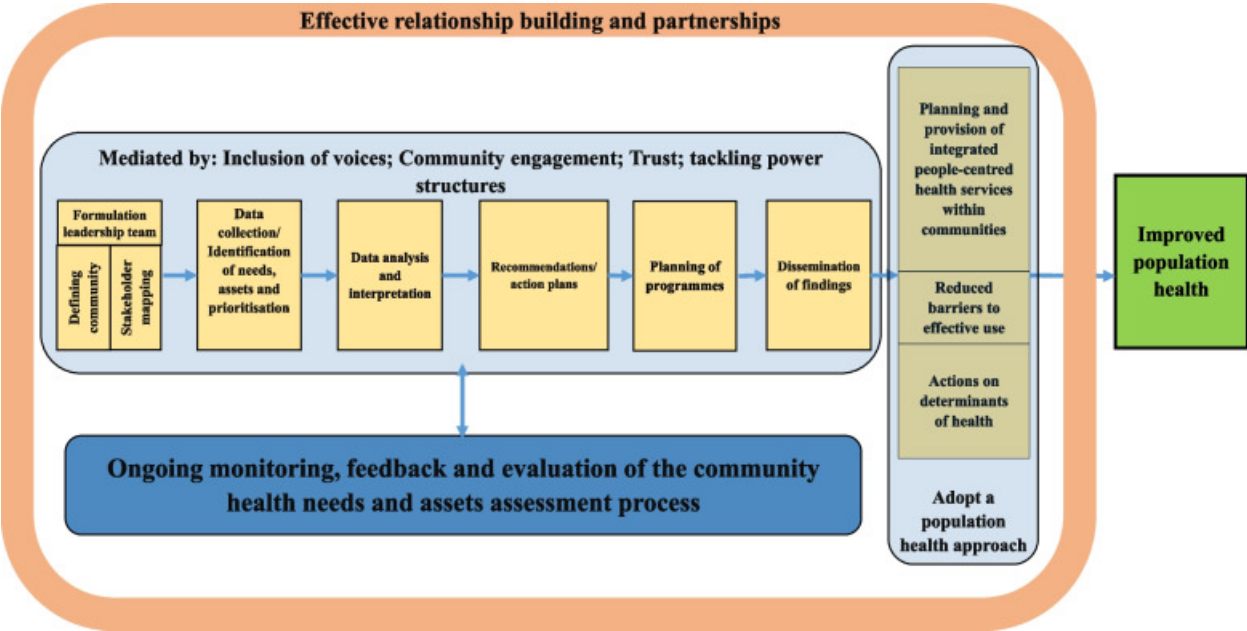


Figure 5.0 A scoping review of community health needs and assets assessment: concepts, rationale, tools, and uses. 2023. <https://pubmed.ncbi.nlm.nih.gov/36650529/>

Appendix C: Health Equity Fact Sheet

Health Disparities are Driven by Social and Economic Inequities



Figure 6.0 Disparities in health and health care. KFF. 2024. <https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/>

Appendix D: Safety Assessment and Health Questionnaire

Referral Received Date: _____ Patient Name: _____

Referral Accepted Date: _____ Address: _____

Phone # _____

Patient home directions, unique characteristics, parking information, etc.:

Any Pets in the home? _____

**Note pets must be place in a separate room for MIH visit.

Personal Assists: Hearing Aides, Glasses, Dentures, Cell phone, Call alarm (circle all that apply)

Adaptive Equipment in the Home: YES NO (note glucometer, respiratory equipment, reacher, sock aid, pill dispense, etc.)

If YES, what equipment: _____

All stairs with railings and in good shape? _____ Electricity working? _____

All rugs secured/tacked down? _____ (No use of unsafe extension cords)

Sink accessible, running water? _____ Laundry accessible? _____

No hoarding/clutter/unsafe furniture? _____ Acceptable room temperature? _____

All medication in appropriate containers? _____ (no pills found loose, no expired meds, controlled meds accounted for?) _____

Bathroom equipment? _____ (note all safety bars, tub benches, bathmat, shower equipment)

Mobility equipment? _____ (note w/c, walker, quad cane, straight cane, cwc, etc.)

Feeding equipment? _____ Does patient have an emergency call system? _____

Stove functional *and* safe? _____ (make sure emergency equipment works)

Smoke detectors present *and* functional. _____ (referral out to FD)?

Prosthetic Equipment? _____ Able to don/don off? _____

Home Health Aide? (note agency and collaborative contact person):

Weapons secured? _____

What language is used in the home? _____

Interpreter needed? _____

Who else lives in the home? _____

May we talk to other people in the home? _____

Is the patient a Veteran? _____

Who is the supplier of the equipment needed? _____

Who is the supplier of medication/ pharmacy? _____

What other services have been requested, and evaluated separate from MIH?

Appendix E. Resources and References

Rural Health Information Hub: Rural Health Information:

<https://www.ruralhealthinfo.org/topics/rural-health-research-assessment-evaluation>

Dial 2-1-1 Resource search for Connecticut:

<https://www.211ct.org/>

FIND HELP: Find free or reduced-cost resources like food, housing, financial assistance, health care:

<https://www.findhelp.org/>

Legislative MIH Workgroup Report:

<https://portal.ct.gov/dph/emergency-medical-services/ems/legislative-mih-workgroup>

Acknowledgements

Recognition is due to the Connecticut Mobile Integrated Healthcare Advisory Committee. Thank you to all the members that contributed their expertise and time to bringing the MIH Program to fruition. The contributions you made are significantly going to help improve healthy outcomes for the residents of Connecticut.

You are greatly appreciated!

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