FIFTH DRAFT

FIRST EDITION ACCREDITATION STANDARDS

FOR

~~COMMUNITY PARAMEDICINE~~

MOBILE INTEGRATED HEALTHCARE (MIH) PROGRAMS

of the

Commission on Accreditation of Medical Transport Systems

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This is the fifth draft of the 1st Edition of the
Mobile Integrated Healthcare (MIH) Program Accreditation Standards
for public comment. To submit comments, suggestions or to recommend changes go to camts.org or go directly to https://www.emailmeform.com/builder/form/as4HdARv5hwlo.

AS OF 3/17/2021

Additions shown in yellow highlight

Deletions shown in gray ~~with strikeout~~

Changes made at the January 14, February 9, and March 11, 2021 meetings of the CAMTS MIH Program Standards Committee.
Sections 01.00.00 and 02.00.00 only
Sections 03.00.00, 04.00.00 an 05.00.00 are still under committee review.

The standards are as appropriate to the state of residence and the specific regulator of that state as referenced by the term “Authority Having Jurisdiction” (AHJ). CAMTS Accreditation Standards, as a measure of quality, are part of a voluntary process and frequently exceed the AHJ’s regulations.

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CM 01.00.00 – MANAGEMENT AND STAFFING

CM 01.00.00 MISSION STATEMENT AND SCOPE OF CARE

CM 01.01.01 There is a Mission Statement written in the present tense that describes the purpose of the service, types of services provided and its constituents. ~~The Mission Statement directs employees toward the values the service was founded upon upon which the service were found. .~~ The Mission Statement reflects the values upon which the service were found.

CM 01.01.02 There is a written scope of service that describes the types of patients accepted (Scope of Care), services provided and exceptions ~~(service that is not provided~~). Scope of Service includes range of services, procedures performed, response time, staffing configuration(s), and any exceptions to types of requests that are accepted. In addition, the scope of services should be defined considering:

1. Improving patient outcomes
2. Reducing individual and health care system costs
3. Reducing hospital admissions and readmissions
4. Improving patient access to care
5. Improving health care system capacity
6. Improving health equity
7. Meeting community needs and expectations
8. Addressing resource availability
9. Building a healthy community
10. Disease ~~P~~prevention and focus on health
11. Assuring financial stability of the program
12. Helping patients identify barriers and meet their goals of care
13. Deliver 5R Model: Right care, Right place, Right timeframe, Right Quality, Right cost

The Scope of Care is commensurate with the qualifications and level of initial and ongoing education required for medical practitioners. The Scope of Care should address, as applicable to the program, patient populations served, age groups and their definition.

Note: The term "patient" is used throughout the standards. Programs may not see all participants in their ~~Community Paramedicine~~ Mobile Integrated Healthcare Program as "patients" and may refer to them as participants, members or other terms. For purposes of the Standards, these terms

CM 01.01.03 There is a comprehensive inventory that identifies the availability and distribution of current capabilities and resources for a variety of partners and organizations throughout the community

<u>*Examples of evidence to meet compliance:*</u>
The Mission Statement describes what you do in a clear and concise manner. The vision and mission are strategic statements developed by and unique to each organization. Values statements are separate but key underpinnings of these statements. The community-wide resource assessment documents the

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resources available in the local community to help meet the clinical, behavioral and social needs of patients that may be enrolled in the community ~~paramedicine~~ MIH program.

CM 01.02.00 FINANCIAL COMMITMENT

CM 01.02.01 There must be evidence of financial commitment to the program by the administrative structure and through financial resources that ~~provide~~ contribute to excellence in patient care and safety.

Examples of evidence to meet compliance:
Vehicles or care sites are well kept – equipment and supplies are well maintained, accessible and adequate for the patient population(s)/volume. Physical administrative surroundings are well maintained. There are adequate management and staff personnel for patient volume. Education appropriate to the scope of care and to all aspects of the organization (communications, practitioners, etc.) is provided.

CM 01.02.02 Insurance – The community medical service must have and maintain insurance against loss or damage of the kinds customarily insured against and in such types and amounts as are customarily carried under similar circumstances by similar businesses. The insurers must be financially sound and reputable, and they must be qualified to do business in the state(s) in which the service is located.

The types of insurance must include but are not limited to the following:

1.. Auto insurance (for ground vehicles owned by the service) – $1 million (U.S. dollars) and includes accidental death and disability

2. ~~Medical Professional Liability~~ General Liability– $1 million (U.S. dollars)

3. Worker's compensation or employer's liability – per state or equivalent government guidelines

4. Group life insurance or accidental death and disability – whether paid for by the employer or employee. A minimal coverage of one times the annual salary is encouraged.

CM 01.03.00 MARKETING AND EDUCATION FOR THE PUBLIC

CM 01.03.01 There is a stakeholder's users' group that provides guidance and consultation on operations and policies relative to the communities served. This group may include (and not limited to):

1. Clinical providers
2. Social Services
3. Public Health
4. Public Safety – Police, Fire, EMS
5. Pharmacy
6. Mental Health (including substance abuse facilities/councilors)
7. Housing organizations/agencies (including homeless shelters)
8. Suppliers (durable medical equipment, gases, medications, etc.)
9. Community leaders
10. Clergy

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11. Emergency Management
12. ~~Interrupter~~ Interpreter Services (foreign language, sign, etc.)
13. Patients and/or patient advocates
14. Hospitals and healthcare systems
15. Third party payers (State Medicaid, insurance companies, etc.)
16. Local/State government

CM 01.03.02 There is a professional and community education program and/or printed information with the target audience to be defined by the community medical service.

1. Clear identification of the sponsoring agency(s) with appropriate contact information.

2. Website information and printed materials are accurate and consistent with program documents, practice and capabilities, including the program's mission and vision statements.

3. Evidence of state licensure (or authority having jurisdiction (AHJ)) is provided for each vehicle and care site as appropriate to state or local guidelines.

4. State or local license (or AHJ) for each vehicle and care site are accessible to the public.

5. Hours of operation, phone number, and access procedure are accessible to the public.

6. Capabilities of medical practitioners--including current scope of care, a list of types of patients who are accepted based on personnel training, and configuration and equipment capabilities--are included.

7. Coverage area for the service is specified.

8. Access requirements to the service are outlined.

9. Patients considered appropriate for service are specified.

Examples of evidence to meet compliance:
Marketing materials are up to date, consistent with mission and scope, depict actual types of services and service area and do not exaggerate the scope of care or capabilities.

CM 01.03.03 There is an annual report provided to the members of the stakeholder's users' group ~~and available to the public~~ that outlines the number of patients served, number of visits, cost of the program, estimated patient and health systems financial cost reduction, patient outcomes, major program changes and overall impact on improving the community served.

CM 01.04.00 ETHICAL BUSINESS PRACTICES

CM 01.04.01 The service develops and demonstrates use of a written code of ethical conduct in all areas of business that demonstrate ethical practices in business, marketing and professional conduct.

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1. The code of conduct guides the service when confronted with potential compliance or ethical issues.

2. The code of conduct outlines the service's standards for ethical behavior as well as contact information and reporting protocols if a standard has been violated.

3. The code of conduct outlines ethical billing practices.

4. Upon request, for elective and/or non-emergent care or services, the program provides the patient, patient family member or third-party payor with a timely written, honest best estimate of the total cost of services.

5. There is a policy that addresses privacy rights in regard to photographing and the use of photos or other media that includes prohibiting photos placed in social media that would compromise HIPAA requirements without a patient's written permission.

Examples of evidence to meet compliance:
Policies may address such issues as proper/improper behavior toward other programs' marketing materials, honesty in reporting data, personal cell phone use, use of social media sites, how ethical issues are addressed, conflicts of interest, phone etiquette, acceptable and unacceptable behaviors on the worksite, acceptance of gifts from patients/vendors, etc.

CM 01.04.02 The Board of Directors, administrative and management staff are encouraged to complete an annual conflict-of-interest statement or form, disclosing any actual or potential conflicts.

CM 01.04.03 Ethical business practices must be maintained in policy and practice and include specific guidelines for service requests that are not performed directly by the CAMTS-accredited service or service seeking accreditation as follows:

1. Referring service requests – Referring is defined as transferring the service request to another program or service. There is no further involvement on the part of the original services, and there is no monetary exchange for the referral.

2. Subcontracted service requests – Subcontracted is defined as the occasion when another service is used to supply a portion of the care, such as testing, mental health, physical therapy, or the medical team, if the service's medical team is not available or is not appropriate.

3. Outsourcing service requests – Outsourcing is defined as transferring a request to another service but retaining control of the coordination throughout the patient care (which may include testing, mental health, physical therapy, etc.) The service may add a fee for coordinating the care, but full disclosure of the name of both the medical provider and the medical care provider employer must be made to the patient, his/her advocate and the payer source(s).

4. Brokering service requests – Brokering is defined as arranging for services and collecting a fee but not actually performing any patient care or taking any patient care responsibilities. This is not an acceptable practice of an accredited service. If the accredited service or service seeking

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accreditation cannot fulfill a request for services, the service may elect to subcontract or refer the request.

5. Communications if unable to provide service – The program will notify the requesting/referring agency, at the earliest possible time, as defined by the agency, when it discovers services cannot be completed. If the request for service is referred, subcontracted or outsourced the requesting/referring agency will be notified of the name and contact information of the program providing service.

CM 01.04.04 The community medical service will know the capabilities and resources of area receiving facilities and will ~~arrange for transport of patients~~ connect patient to transport options, when necessary, to appropriate facilities within the service region based on patient preference, medical protocols, direct referral, approved EMS plan, or services available when no direction is provided.

1. Contractual relationships with public services or health care agencies do not reflect implied referrals.

2. Subscription services do not reflect implied referrals that could negatively impact expeditious transport of patients to the most appropriate facility.

Examples of evidence to meet compliance:
Contracts do not exceed current market value for goods and/or services or severely discount current market value with the intent to influence requests or referral patterns.

CM 01.04.05 All patient care resources, including personnel and equipment, necessary to the program's mission must be readily available and must be operational prior to initiating a patient encounter.

CM 01.05.00 COMPLIANCE

There is a corporate compliance officer or designated person responsible for ensuring that the service is following external laws and regulations, payer requirements and internal policies and procedures.

CM 01.05.01 Compliance issues may include but are not limited to:

1. Health Insurance Portability and Accountability Act (HIPAA)*

    a. If a program is using a form of telemedicine/telehealth, there are policies and procedures that outline how patient privacy issues are protected.

2. Federal civil statutes (False Claim Act)*

3. Balanced Budget Act of 1997*

4. Office of Inspector General (OIG) Compliance Program Guidance*

5. OIG annual work plans *

6. Anti-kickback and Stark laws*

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7. Emergency Medical Treatment and Active Labor Act (EMTALA)*

8. Red Flag Rules (Identity Theft Prevention Program) *

9. Federal sentencing guidelines

10. Or applicable ~~national~~ state or federal regulations

** (See References)*

CM 01.05.02 The compliance program includes:

1. Written policies and procedures

2. Designation of a compliance officer or assignment of responsibility to a specific individual or individuals

3. Effective training and education for staff that documents both initial and continuing competency

4. A process that allows and encourages staff to report competency concerns or accidental infractions without fear of retaliation.

5. Effective lines of communication

6. Enforced standards based on published progressive disciplinary guidelines

7. Auditing and monitoring

8. Procedures for responding to detected offenses and taking corrective action

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

CM 01.05.04 When appropriate, the program actively participates as an integrated part of the state(s) EMS system in which it responds.

CM 01.05.05 The program integrates with external regional healthcare stakeholders to assess the overall program effectiveness. A formal assessment and recommendation report is completed at least every two years.

Examples of evidence to meet compliance:
Staff is knowledgeable about current compliance issues.

CM 01.06.00 MANAGEMENT/POLICIES

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CM 01.06.01 There is a well-defined line of authority.

1. There is a clear reporting mechanism to upper-level management. An organizational chart defines the chain of command and how the community medical service fits into the governing/sponsoring institution, agency or corporation.

2. For public or private institutions and agencies that contract with a community medical service, there must be a policy that specifies the lines of authority between the medical management team and the public or private institutions' management team.

3. All personnel understand the chain of command.

4. Managers are oriented to community medical standards and state regulations or AHJ pertinent to community medical services.

5. Managers are trained to recognize real and perceived pressures that may influence unsafe acts by staff.

6. The program adheres to state, national and/or local community ~~paramedicine~~ MIH rules and regulations, including licensure requirements.

7. A policy must be in place that documents the employer's progressive disciplinary process and protects employees from capricious actions.

8. There is a policy that addresses DNR orders.

9. There is a policy that addresses transfer and security of patient's personal property.

10. There is a comprehensive directory of regional patient care and service resources.

11. Management:

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

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

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

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Examples of evidence to meet compliance:
Business plans demonstrate a needs and risk assessment when expanding the service or adding sites, and those plans include staffing, training and management restructuring for added responsibilities.

Examples of evidence to exceed compliance:

Management is educated to Just Culture and applies Just Culture principles throughout the organization.

CM 01.06.02 Employment Policies

1. A policy addresses pre-hire background checks that include, at a minimum, criminal background, license verification, and previous employer.

2. A policy addresses annual driving record checks and license verifications.

3. A policy requires staff to self-report any investigation, arrests, or convictions.

4. A policy addresses pre-hire (whether or not it is required) drug screening.

5. A policy addresses criteria to require "for cause" drug screening.

6. A policy addresses a procedure for employee terminations that ensures protection of program information, physical and electronic data, property, and security. This may include securing the individual's badge/keys/other access devices, deactivating e-mail accounts/computer sign-ons/remote access/codes, remaining with employee until leaving the premises, inspecting items employee takes with him or her, providing prompt notification of relevant departments/vendors/contractors and patients, procuring property that belongs to the program that the employee may have off site, etc.

CM 01.06.03 Policy Manual (electronic or hard copy) is available and familiar to all personnel

1. Operational and administrative policies must reflect current practice and are reviewed on a biennial basis as verified by dated manager's signature on a cover sheet or on respective policies.

Examples of evidence to meet compliance:

Policies can be broken out by department/division; however, there must be signatures and revision dates on each specific policy or a cover sheet that represents biannual review with respective review dates and signatures.

CM 01.06.04 Programs are encouraged to develop a plan for succession and unanticipated extended absence for key positions. The plan should address position vacancies, including when there is no incumbent to provide transition training, as well as unplanned extended temporary absences, designed to preserve the integrity of the program.

Examples of evidence to meet compliance:

This may include cross-training, identification of successors with support of formal and informal education, mentorship, opportunities to participate in projects/presentations/events in the future role, scenarios/case studies, shadowing, job expansion, mechanisms to preserve and provide access to needed information/documents, contacts lists, task lists, detailed instruction on processes that are critical/known only to the position and periodic review/updating of the plan's references.

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CM 01.07.00 STAFFING

The service must have written operational policies to address each of the areas listed below:

CM 01.07.01 Scheduling and individual work schedules demonstrate strategies to minimize duty-time fatigue, length of shift, number of shifts per week and day-to-night rotation. (See References for circadian rhythm, Fatigue Risk Management System (FRMS) and other fatigue studies.)

1. Medical practitioners must have the right to call "time out" and be granted a reasonable rest period if the team member (or fellow team member) determines that he or she is unfit or unsafe to continue duty, no matter what the shift length. There must be no adverse personnel action or undue pressure to continue in this circumstance.

2. Management must monitor patient care volumes and service times and the personnel's use of a "time out" policy.

3. A written policy addresses the scheduling of on-call shifts, and that policy addresses fatigue by requiring managers to monitor duty times, by tracking QM, and by using fatigue risk management.

4. A written policy or risk assessment defines the number and types of medical practitioners to be sent on each patient visit. The personnel level of certification/license and training should be matched to the needs of each patient.

5. Personnel must have at least 10 hours of rest with no work-related interruptions prior to any scheduled shift of 12 hours or more or prior to any on-call shift of greater than 12 hours that is scheduled to precede or follow a scheduled on-duty 12-hour shift. The intent is to preclude back-to-back shifts with other employment, educational requirements or school, ~~commercial or military flying~~, or significant fatigue-causing activity prior to a shift.

6. The number of consecutive shifts and day-to-night rotations must be closely monitored by management for practitioners, communication specialists, vehicle operators and maintenance personnel.

7. A written policy addresses safety and clinical competency requirements for part-time or full-time staff experiencing a low volume of service responses. The policy should assure all staff are current and competent to the level of full-time, active staff in safety and the use of clinical equipment.

Examples of evidence to meet compliance:
Management monitors fatigue in terms of staffing patterns, patient outcomes and incidents or accidents with implementation to include Just Culture.

CM 01.08.00 PHYSICAL WELL-BEING

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CM 01.08.01 Physical and psychological/emotional well-being is promoted through:

1. Wellness programs that promote healthy lifestyles (e.g., balanced diet, weight control, no smoking)

2. Resources to promote psychological and emotional well-being such as suicide prevention training, trained peer support team, and how to access employee assistance programs (strongly encouraged)

3. Evidence of an injury prevention program and ergonomic strategies to reduce employee injuries

4. Protective clothing and dress code pertinent to:

   a. A ~~uniform,~~ professional dress code appropriate to the area served

   b. Personnel Protective Equipment (PPE) based on the patient encounter

   c. Safe operations appropriate to the environment and time of year. ~~, which may include the following, unless specified as "required" below:~~

   - ~~Sturdy footwear~~
   - ~~Reflective material or striping on uniforms for night operations~~
   - ~~High-visibility reflective vests or appropriate Department of Transportation (DOT)-approved clothing worn by medical practitioners in accordance with ANSI-SEA 107 standard or equivalent national standard (required for medical crews and vehicle operators responding to night scene requests)~~
   - ~~Appropriate outerwear pertinent to the environment (required)~~

5. Infection control – dress codes address jewelry, hair and other personal items of medical personnel that may interfere with patient care. Refer to Occupational Safety and Health Administration (OSHA) standards.

6. Written policies addressing:

   a. Duty status during acute illnesses, fever, cough, etc.

   b. Duty status while taking medications that may impair performance related to safety

   ~~c. Weight/height and/or lifting ability as specified in pre-hire requirements or job description~~

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Examples of evidence to meet compliance:
Personnel are observed following the program's dress codes and are knowledgeable about policies regarding physical well-being. Policies are consistent with current national laws and may address notification to employer requirement, written documentation requirements to continue on duty, possible alternative duty assignments if team member is restricted from duty.

CM 01.09.00 MEETINGS AND RECORDS

CM 01.09.01 Meetings

1. There are formal, periodic staff meeting for which minutes are kept on file.
2. All meeting minutes (Staff, Safety, QM, etc.) include the following:
   a. Date and time of the meeting
   b. Base identification (if multiple bases)
   c. Meeting type (Staff, Safety, QM, etc.)
   d. List of those in attendance by both name and title or function (i.e., Director, Community Health Worker, RN, Paramedic, Community Paramedic, EMT, Etc.)
   e. Name of the person presiding
   f. Discussions (versus just agenda/topic headings)
   g. Assignments and responsibilities for open issues
   h. Progress reports on open issues
   i. Clear identification that an issue has been resolved (loop closure)
3. There are defined methods, such as a staff notebook or digital mechanism, for disseminating information between meetings.
4. All meeting minutes (Staff, Safety, QM meetings, etc.) are kept on file and maintained for a minimum of three years.

Please note that Staff, Safety, QM, UM meetings can be done separately, in combination or during the same meeting. If combined, the meeting minutes should clearly have sections identified for each.

Examples of evidence to meet compliance:
Meeting minutes indicate attendance and representation by all disciplines. Action items, timelines and area of responsibility are well documented and demonstrate a flow of information that indicates tracking, trending and loop closure.

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CM 01.09.02 Records Management ensures that patient care records, meeting minutes, policies and procedures are stored according to hospital or agency policies, and HIPAA or privacy regulations are indicative of the individual community medical service's sensitivity to patient confidentiality in accordance with local and national standards.

1. A record of patient care is completed electronically and is used for assessment of system performance and quality of care and serves as a bi-directional exchange of patient contact information with others associated with the patient's medical care. This includes, but may not be limited to, Primary Care providers, case managers, social service agencies and payers.

a. A policy outlines minimal requirements based on the community medical service's scope of care.

- Reason for care/services provided
- History and trending of present illness/injury, physical exam, weight, vital signs, and pain assessments, per patient needs assessment and program's guidelines
- Diagnosis/impression
- Allergies
- Treatments and medications and patient's response to treatments, procedures, and medications. This includes an inventory of all medications (prescription and non-prescription). ~~and a reconciliation with physician orders.~~
- Documentation of pertinent imaging and laboratory reports including Point of Care work.
- A care plan, with outcome goals, as outlined by the referring physician/agency or accepted by the program medical direction.
- Assessment of the patient's home environment including home safety (fall risks), health routines and living habits.
- Documentation of additional referrals to in-home support services, community resources (such as behavioral health and case management) and assistance with coordination of follow-up appointments.
- Documentation if telehealth was performed, with which provider and any orders given.
- Signature of each care provider and clarity about what care was performed by each provider(administering medications and performing procedures) and indicates who actually documented patient information

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- A plan for continuity of the medical care including how records will be documented, stored and shared and to whom the report is given.

b. ~~A patient care summary, with medication reconciliation and patient instructions, is left with the patient at the conclusion of each visit.~~ A policy outlines what information and instructions will be left with patients. This information should also include contact information for ~~additional information~~ follow-up when needed.

c. A policy outlines approved abbreviations for use in patient care records. ~~Medication abbreviations are avoided~~. To minimize medication errors risks, the use of the Institute of Safe Medication Practice (ISMP) “Do Not Use” Abbreviation List is strongly encouraged.

d. The electronic healthcare record is capable of documenting medication regiment ~~s~~ accurately and appropriately.

e. A policy outlines the expectations for completion of patient care records in a timely manner. (i.e. 90% completed within 24 hours)

f. A stored permanent electronic patient care record is preferred, but scanned hard copies are acceptable. Where possible, the ~~community paramedicine~~ medical record should be part of, and/or, ~~uploaded~~ made available to the referring hospital or physician medical record system(s).

Examples of evidence to meet compliance:
Patient records are signed and initialed by the practitioners who performed the treatment or procedure. Records are stored in a secure area that is inaccessible to the public with accessibility limited according to applicable HIPAA guidelines.

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CM 02.00.00 – ~~COMMUNITY PARAMEDICINE~~ MOBILE INTEGRATED HEALTHCARE QUALITY MANAGEMENT

Includes Quality, Utilization and Safety Management

CM 02.00.00 QUALITY MANAGEMENT

Management monitors and evaluates the quality and appropriateness of the ~~community paramedicine~~ mobile integrated healthcare service through an active Quality Management (QM) program, including the following:

CM 02.01.01 A QM flow chart diagram or comparable tool is developed demonstrating organizational structure in the QM plan and linkage to the Safety Management System.

CM 02.01.02 The QM plan should emphasize that the quality of services offered is considered on a continuum, with constant attention to developing new strategies for improving. Maintaining the status quo or achieving arbitrary goals are not considered the end-measures.

CM 02.01.03 The QM program should be integrated and include activities related to patient care (including customer satisfaction and employee satisfaction), communications, and all aspects of community ~~paramedicine~~ MIH operations and equipment maintenance pertinent to the service's mission statement. Involvement with community partners is strongly encouraged.

CM 02.01.04 There is an ongoing Quality Management (QM) program designed to monitor, assess and improve the quality and appropriateness of patient care and safety of the community ~~paramedicine~~ MIH service objectively, systematically and continuously.

CM 02.01.05 The QM program includes clinical experts as defined by the program's mission statement and scope of service.

CM 02.01.06 Promotes the effectiveness of the QM program through active participation by management and staff in the program and by sponsoring active communication pathways bi-directionally between staff and management.

CM 02.01.07 The QM Program is linked with risk management, so that concerns identified through the risk management program can be followed up through the continuous quality improvement program:

1. There is a written policy that outlines a process to identify, document and analyze sentinel events, adverse medical events or potentially adverse events (near misses) with specific goals to improve patient safety and/or quality of patient care.

2. There is follow-up on the results of actions /goals for specific events until loop closure is achieved.

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3. The process encourages personnel to report adverse events even if it is a sole source event (only the Individual involved would know about it) without fear of punitive actions for unintentional acts.

CM 02.01.08 The ~~community paramedicine~~ mobile integrated healthcare service has established patient care guidelines/standing orders that must be reviewed annually (for content accuracy) by management, QM Committee members and the Medical Director(s).

CM 02.01.09 The Medical Director(s) is responsible for ensuring timely review of patient care

CM 02.01.10 There is an established QM program in place that includes:

1. Responsibility/assignment of accountability

2. Scope of care

3. Important aspects of care, including clinical outcomes

4. Operational processes such as financial outcomes and customer needs

5. Quality indicators (Key Performance Indicators)

6. Thresholds for evaluation appropriate to the individual service

7. Methodology - the QM process or QM tools utilized and how individual indicator scores are measured/calculated.

8. Evaluation of the improvement process

9. Assuring integration of care with the patient's physicians and health care system.

~~10. Patient satisfaction surveys~~

~~11. Provider satisfaction surveys~~

10. Stakeholder satisfaction surveys
    - Providers
    - Clinical Staff
    - Other Partners

CM 02.01.11 For both QM and utilization review programs, there should be evidence of actions taken in problem areas and evaluation of the effectiveness of that action.

Examples of evidence to meet compliance:

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Development of quality metrics that will allow the program to improve in their processes should be developed with indicators focusing on every aspect of the program (i.e. coordination, clinical, safety, etc.) A flow chart outlining the process flow when outliers and how the loop is closed to ensure that each outlier was addressed. Subsequent action to trends in activity should be noted with constant evaluation of the performance improvement process (i.e., Deming Cycle; Plan, Do, Study/Check, Act). The QM plan is current and describes the process with evidence of loop closure in subsequent reports.

CM 02.01.12 There will be regularly scheduled QM meetings providing a forum for all disciplines involved in the community paramedicine MIH service to present their needs and areas for improvement to each other. Minutes will be taken and distributed to management and staff not participating in the meetings.

CM 02.01.13 The monitoring and evaluation process has the following characteristics:

1. Driven by important aspects of care and operational practices identified by the community paramedicine service's QM plan

2. Indicators and thresholds or other criteria are identified to objectively monitor the important aspects of care.

3. Evidence of QM studies and evaluation in compliance with written QM plan

4. Evidence of action plans developed when problems are identified through QM and communication of these plans to the appropriate personnel

5. Evidence of reporting QM activities through established QM organizational structure

6. Evidence of on-going re-evaluation of action plans until problem resolution occurs

7. Evidence of annual goals established prospectively for the QM program which provide direction for the work groups and which are quantitative. The emphasis must be on loop closure and resolution of problems within a finite time period.

CM 02.01.14 Quarterly review should include at a minimum, but may exceed, criteria based upon the important aspects of care/service. The following examples are encouraged:

1. QM personnel may collect data and refer to the Safety Committee for action and resolution.

2. Operational criteria to include at a minimum the following quantity indicators:

   a. Number of completed service visits.
   b. Number of aborted and canceled service visits (defined as departed but never completed the visit) (i.e.: patient not home, patient refused to be seen, diverted to another location, etc.)
   c. Number of missed services visits and reasons missed (defined as unable to accept the service request) (i.e.: lack of staff, system capacity, lack of vehicles, etc.)
   d. Number of patient that have "graduated out" and are no longer in need of the

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program's services.

e. Number of rescheduled visits by patient or provider

3. Service visits delays and reason.

4. Change in patient's condition that required additional interventions

5. Never events (see references)

6. Requests of additional emergency response from EMS, public safety or emergency psychiatric services.

7. Patients with known communicable disease at the time of the request or discovered after the service visit.

8. Patient ~~c~~ Complaint findings and improvements made

~~9. Provider complaint findings and improvements made~~

Examples of Evidence to Meet Compliance:
The QM plan is current and describes the process with evidence of loop closure in subsequent reports. QM does not consist only of medical record reviews.

Examples of Evidence to Meet Compliance:
Outcomes from QM should drive systems/process/procedures changes, education and training needs. Systems improvement tools are educational. The process is not directed toward an individual nor is it punitive.

Tracking and trending of the time between the referral and first encounter and times at the service locations are evaluated in terms of benchmarks set by the program in order to evaluate the effectiveness of policies/procedures, training and/or equipment needs. If services are delayed, reasons for delays are tracked as are service requests that are conducted by alternate medical service providers.

CM 02.02.00 UTILIZATION MANAGEMENT (UM)

Management ensures an appropriate utilization management process through trending and tracking requests. Utilization review may be prospective, concurrent, or retrospective.

CM 02.02.01 Management ensures an appropriate utilization management process based on:

1. Benefits to the patient (medical, psychosocial, community health)

    a. Timeliness of the services as it relates to the patient's clinical status

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a. Patient care needs consistent with the capabilities and limitations of the community medical service and the medical providers' skills

b. Patients' own assessment of improvement or impact in quality of life, including pain and discomfort, use of medications, mobility, self-care, patient's out-of-pocket medical expenses, anxiety/depression and performance of usual activities

2. Safety of the ~~community paramedicine~~ mobile integrated healthcare environment

3. A structured, periodic review of services (to determine service appropriateness, safety or cost effectiveness over other types of medical care) performed at least semiannually and recorded in a written report. This report indicates criteria have been tracked and trended and feedback was provided when there are inappropriate requests from referral and contacting agencies.

~~4. The following criteria trigger a review of the record to determine medical appropriateness based upon patients:~~

~~a. Who have needs not reported by the requesting agency~~

~~b. Who are served by an inappropriate provider in consideration of time, distance or speed, etc.~~

~~c. Who are served by an inappropriate team, i.e., Primary Care Provider used but patient required Advanced Care or social services or when social services referrals were made when Primary Care is the immediate need.~~

5. Expenditure and cost of care (by patient and in aggregate) (encouraged)

a. Trending of emergency medical service requests, emergency department visits, hospital and nursing facility inpatient admissions, inpatient days and physician office visits prior to and following establishment of care by the ~~community paramedicine~~ MIH program.

b. Tracking and trending of patient improvement/changes including patient self-assessment of general health and pre and post intervention (blood pressures, smoking cessation, A1C, BMI, Etc.)

c. Number of program visits

d. Cost and cost avoidance of emergency department, inpatient care and physician office visits

e. Cost of program visits

f. Source of the referrals

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CM 02.02.02 Management ensures that steps are taken to reduce those services that are considered to be non-appropriate.

Examples of Evidence to Meet Compliance:
UM reports indicate trending and loop closure of patient outcomes. Requesting agents are contacted if there are trends that indicate over-triage or under-triage. Continuous review of UM with applicable trending and loop closure of patient outcomes in the form of follow-up with receiving facility, documented phone calls to patient/family, etc. may provide adequate information about patient outcome. Outliers should be presented to a QM Committee or during regularly scheduled staff meetings to discuss specifics of the service provided.

CM 02.03.00 SAFETY MANAGEMENT
(includes Safety Management Systems and Safety and Environment)

CM 02.03.01 Safety Management System - Management is responsible for a Safety Management System (SMS) but both management and staff are responsible for ensuring safe operations. The Safety Management System is proactive in identifying risks and eliminating injuries to personnel and patients and damage to equipment and includes:

1. A statement of policy commitment from the accountable executive

2. Designate a ~~dedicated~~ Health & Safety Officer

2. Risk identification process and risk management plan that includes a non-punitive system for employees to report hazards and safety concerns

3. A system to track, trend and mitigate errors or hazards

4. A system to track and document incident root cause analysis

5. A Safety Manual

6. A system to audit and review organizational policy and procedures, ongoing safety training for all practitioners (including managers), a system of proactive and reactive procedures to insure compliance, etc.

7. A process for dissemination of safety issues to all personnel for loop closure

8. There is evidence of management's decisive response to non-compliance in adverse safety or risk situations.

   a. Senior leadership should establish a process to identify risk escalation to ensure that safety and risk issues are addressed by the appropriate level of management up to and including the senior level.

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b. Operational Risk Assessment tools should include but not be limited to issues such as: service acceptance, public relations events, and training., ~~maintenance and re-positioning trips.~~ For service, the tool should include:

- Assessing fatigue

- Clinical acuity of patient

- Potential risks related to:
    1. Single provider services
    2. Location and environment of the area were services are provided including safety of the residences or building
    3. Other at-risk individuals at the home
    4. Communicable disease
    5. Use of marked vs unmarked vehicles
    6. Use of provider uniforms
    7. Proper Use of PPE
    8. Bloodborne Pathogen and Needlestick safety
    9. Compliance with Ryan White Act

- Foreign language considerations (does the care provider speak local language)

- Experience of medical provider

- Other temporary situations in areas traveled that may increase risk (for example, extreme weather forecasted, recent/impending political or natural disaster, etc.)

9. Policies address practitioner safety and include but are not limited to the following examples:

a. Cultural intelligence

c. Checking with local law enforcement regarding high-risk areas.

d. Accountability with respect to the location of the provider, in case of needing assistance (i.e., location tracking, check in etc.)

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

a. Accountability – employees are held accountable for their actions

b. Authority – those who are responsible have the authority to assess and make changes and adjustments as necessary

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- Standards, policies and administrative control are evident
- Written procedures are clear and followed by all
- Training is organized, thorough and consistent according to written guidelines
- Managers represent a positive role model promoting an atmosphere of trust and respect

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

d. Organizational Dynamics

- Teamwork is evident between management and staff and among the different disciplines regardless of employer status as evidenced by open bi-directional and inter-disciplinary communications that are not representative of a "silo" mentality.
- Organization represents a practice of encouraging criticism and safety observations, and there is evidence of acting upon identified issues in a positive way.
- Organization values are clear to all employees and embedded in everyday practice.
- Use of Just Culture

11. A Safety Management System includes all disciplines and processes of the organization. A Safety Committee is organized to solicit input from each discipline and should meet at least quarterly with written reports sent to management and kept on file as dictated by policy

a. Safety issues should be identified by the Safety Committee with detailed reporting and analysis of vehicle/patient safety ~~aircraft incidents~~, travel and cultural incidents that could potentially affect crew safety and resolution of issues with findings.

b. The committee will promote interaction between medical practitioners and communications personnel addressing safety practice, concerns, issues and questions.

c. There is evidence of action plans, evaluation and loop closure.

12. The Safety Committee is linked to QM and risk management

13. Vehicle related events that occur during a medical visit are identified and tracked to minimize risks. (See Glossary in Appendix for definition of event)

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

~~14. Participate in a Patient Safety Organization (PSO) as possible~~
~~15. Participate in near miss reporting system~~
~~16. Just Culture~~ (moved up to # 10 above)
~~17. TeamStepps/CRM program~~

CM 02.04.00 SAFETY AND ENVIRONMENT

CM 02.04.01 Patient and personnel security

1. A policy addresses the security of the physical environment where services are to be provided.

2. A policy addresses cyber security and the protection of program and patient information.

3. Personnel security - Medical staff are required to carry program issued photo identification cards with their first and last names and identification as a community health provider. A driver's license and\or passport shall also be carried while on duty. If required ~~but~~ by local or state law, the provider's current certification or license identification must also be carried.

~~4. Patient security - Patients and accompanying family/companion(s) must be properly identified and listed by name (in compliance with HIPAA regulations) in the communications/coordination center by the service coordinator.~~

~~5. Have two-way radio communication capability and panic button, tracking of staff via GPS/AVL~~

4. A comprehensive communications plan addresses two-way communications. The plan may include the use of panic buttons and location identification.

Examples of Evidence to Meet Compliance:
Policy requires wearing or carrying ID's while on duty

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CM 02.05.00 SAFETY EDUCATION

CM 02.05.01 Education Specific to Safety of the ~~Community paramedicine~~ Mobile Integrated Healthcare Environment -   Completion of all the following educational components should be documented. These components should be included in initial education as well as reviewed on an annual basis with all regularly scheduled, part-time or temporarily scheduled medical practitioners as appropriate for the mission statement and scope of practice of the service.

1. Communications strategies and back-up plans

2. Specific capabilities, limitations and safety measures

3. Survival training/techniques/equipment that is pertinent to the environment/geographic coverage area of the medical service but must include at a minimum:

   a. Safety and survival equipment requirements

   b. Confrontation de-escalation and self defense

4. General safety to be included on an annual basis.

   a. Driver training and safety if part of the medical providers responsibilities

   b. Safety around the vehicle and work sites (residences, scenes, homeless shelters, etc.)

   c. Bloodborne pathogen training

   d. Annual fit testing in compliance with NIOSH for respirators

5. General vehicle safety including:

   a. Loading/unloading equipment and supplies

   b. Seat belt use

   c. Securing loose items/equipment

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