Purpose: To establish minimum and consistent requirements for MDHHS approved CIP Special Study programs throughout Michigan.

I. Definitions and Acronyms
   a. CIP – Community Integrated Paramedicine: The MDHHS umbrella term. encompassing both Community Paramedicine and Mobile Integrated Health
      i. CP – Community Paramedicine: Providers possess broad based MDHHS approved education. CP programs may conduct both scheduled and unscheduled visits as approved by the MCA and may take referrals directly from the 9-1-1 system.
      ii. MIH – Mobile Integrated Health: Providers possess focused MDHHS approved education enabling them to conduct care outlined in a single MDHHS approved CIP protocol. MIH programs conduct scheduled visits.
   b. CP – Community Paramedic: A paramedic who has successfully completed an MDHHS approved community paramedicine education program.
   c. MIH Paramedic – Mobile Integrated Health Paramedic: A paramedic who has fulfilled the education requirement set forth by the MCA to conduct care as outlined in a MDHHS approved CIP protocol.
   d. CPU – CP Unit: A vehicle licensed as and compliant with MDHHS standards as an ALS transporting vehicles, or an ALS non-transporting vehicle. A CP Unit must be utilized to conduct any, and all CIP care with the single exception of a community outreach provider visit **see Community Outreach Provider Visit protocol.**
   e. CIP MD - Community Integrated Paramedicine Medical Director – Physician with oversight for CIP program (s). This may be the MCA Medical Director or an MCA and MDHHS approved designee.
   f. QATF – Quality Assurance Task Force
   g. SDOH - Social Determinants of Health – “conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes” (CDC).

II. CIP Program Requirements
   a. All CIP programs must:
      i. Be approved by MDHHS as a Special Study.
      ii. Be approved by the MCA.
      iii. Possess a CIP Medical Director approved by the MCA and MDHHS.
      iv. Utilize only personnel that have met MDHHS education requirements
      v. Conduct care within the parameters of the MCA’s adopted MDHHS approved protocols
      vi. Comply with MDHHS guidelines.
      vii. Further and without contradiction to MDHHS guidelines, comply with MCA guidelines.
      viii. Further and without contradiction to MDHHS or MCA guidelines, comply with agency guidelines.

b. CIP Special Study programs are allotted an initial 3-year term to provide services.
    i. CIP Special Study programs may be terminated at any time by the privileging MCA or MDHHS for failure to comply with MDHHS or MCA requirements.
    ii. CIP Special Study programs will be reviewed by the QATF 3 years after the initial approval date. Programs will be:
        1. Continued as special studies with continued MDHHS oversight and reviews
        2. Discontinued

III. CIP Protocol Requirements

a. All CIP programs will adopt the following MDHHS approved protocols, or an MCA adapted version approved by MDHHS which achieves the same goals:
    i. CIP Program Policy.
    ii. CIP Medical Director Role & Responsibility.
    iii. CIP Medical Direction.
    iv. CIP Scope of Service/Treatment Capability.
    v. CIP Documentation.
    vi. CIP Program Enrollment
    vii. CIP Patient Service Plan/Care Plan
    viii. CIP Program Discharge
    ix. CIP Fall Risk Reduction Assessment
    x. CIP SDOH Assessment
    xi. CIP Medication Audit
    xii. CIP Patient General Assessment and Care
b. All CIP programs will have MDHHS approved protocols that address the following:
    i. CIP procedures performed.
    ii. CIP medications administered.
    iii. CIP treatments and focused populations served.
c. All CIP programs will have protocols or MCA and MDHHS approved policies and procedures that address:
    i. Personnel requirements.
    ii. Minimum staffing requirements.
    iii. Dispatching requirements.
    iv. Personal vehicle usage.
    v. Vulnerable adult recognition.
    vi. Reporting process for suspected adult or child neglect, abuse, or exploitation.
    vii. Patient encounters outside of work.
    viii. Self-reporting for suspected errors.
    ix. Receipt of gifts.
    x. Conflict of interest language that prohibits providers from entering relationships or signing documentation that results in a recognized

position of authority or advocacy on the patient's behalf regardless of legal recognition

d. Protocols must be reviewed minimally every 3 years
e. In the event an MCA has adopted procedure or treatment protocols which do not apply to all CIP programs within the MCA, it will be up to the MCA develop a Quality Assurance system to ensure programs are only utilizing medications and the corresponding protocols for which they are credentialed.

IV. Reporting Requirements

a. CIP Data Submission
   i. All CIP programs will submit MDHHS required data directly to MDHHS on the quarterly basis that a minimum will include:
      1. Number of visits conducted (both unique patients and total number of visits)
      2. Number of patients that accepted enrollment into the CIP program (if applicable)
      3. Average number of patients enrolled at any given time during the quarter (if applicable)
      4. Number of patients that received at least one CIP Fall Risk Reduction Assessment
      5. Number of patients receiving at least one CIP Fall Risk Reduction Assessment in which a correction or referral needed to be made
      6. Number of patients that received at least one CIP Medication Audit
      7. Number of patients that received at least one CIP Medication Audit in which a correction or referral needed to be made
      8. Number of patients that received at least one CIP SDOH Assessment
      9. Number of patients that received at least one CIP SDOH Assessment in which a correction or referral needed to be made
      10. Number of CIP calls that ended in a disposition of patient being transported to or sent to the emergency room by any mode of transportation.
      11. Additional MDHHS reporting requirements will be based on the CIP programs specific lines of service.
   ii. All CIP programs will submit MCA required data to the MCA per the schedule established by the MCA.
   iii. MCA's will submit all collected data to MDHHS on the quarterly basis.
b. The following events must be reported to the CIP-MD and the MCA within 24 hours of the occurrence regardless of conclusion of an investigation.
   i. Death of a patient suspected to be related to the actions or inactions of a CIP provider or program.
   ii. Illness or injury suspected to be related to the action or inactions of a CIP provider or program.

iii. Accusations of misconduct, practicing outside of the established protocol dictated scope of CIP practice or abuse of power.

CIP MEDICAL DIRECTOR ROLE AND RESPONSIBILITIES

Purpose: To outline the roles and responsibilities of the CIP Medical Director.

I. A CIP Medical Director will be the MCA Medical Director and additionally may be
   a. ☐ A physician appointed by the MCA Medical Director and approved by both the Medical Control Board and MDHHS (optional)

II. CIP Medical Director responsibilities:
   a. Medical operations of specified CIP program(s)
   b. Development of CIP protocols
   c. CIP personnel criteria and selection process
   d. Credentialing (MCA privileges) of CIP personnel
   e. Establishing a quality assurance process and schedule which must be approved by the following:
      i. MCA
      ii. MDHHS
   f. Remediation of CIP personnel, as necessary.
      i. MDHHS and the MCA Medical Director must be advised of any CIP requiring remediation within 30 days of the incident
   g. Development and oversight of CIP continuing education
   h. Data submission to the MCA
   i. Data submission to MDHHS

III. The CIP MD privileges are at the discretion of the MCA Medical Director and the MCA Board. CIP Programs are not allowed to function in an MCA without expressed approval from the MCA and MDHHS.

Medical Direction

I. CIP providers will be continuously monitoring for signs of life-threatening or urgent but not life-threatening medical needs. If a CIP provider encounters:
   a. Life threatening medical needs
      i. Initiate local 9-1-1 response
   b. Urgent but not life-threatening medical needs beyond what is written in the orders for the visit.
      i. May initiate local 9-1-1 response prior to establishing online medical direction
      ii. Hierarchy for establishing online medical direction.
         a. First contact – MCA approved referring physician
         b. If unsuccessful, second contact will be the MCA approved referring physician's on-call service provider
         c. If unsuccessful, third contact will be the CIP Medical Director (if applicable)
         d. If unsuccessful, fourth contact will be the MCA's online medical control
         e. If unsuccessful, initiate local 9-1-1 response

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II. Non-Urgent Medical Needs
   a. Medical Direction for CIP visits that lack immediate life-threatening or urgent medical needs may be provided by:
      i. Online MCA Medical Direction
      ii. MCA approved referring physician
      iii. MCA approved Primary Care Physician (PCP)

Purpose: To communicate the program types, patient protocols, and procedures allowed within the MCA. Marked categories will have corresponding protocols. MCA's will track and report to MDHHS the protocols applicable to each CIP Program.

1. CIP Program Types will include (choose from the following):
   - II. Scheduled appointment and physician's order using **Community Outreach Provider Visit protocol** (no minimum vehicle requirement)
     - a. ☐ Community Paramedic (optional)
     - b. ☐ Mobile Integrated Health Paramedic (optional)
   - III. Scheduled appointment for enrolled patient
     - a. Community Paramedic
     - b. ☐ Mobile Integrated Health Paramedic (optional)
   - IV. Episodic (unscheduled) care for an enrolled patient.
     - a. Community Paramedic
     - b. ☐ Mobile Integrated health Paramedic (optional)
   - V. Low acuity 9-1-1 calls
     - a. Community Paramedic
2. Patient protocols
   - a. Will include:
     - i. CIP Patient General Assessment and Care
   - b. May include:
     - i. ☒ CIP Diabetic Care
     - ii. ☒ CIP Asthma Care
     - iii. ☒ CIP Chronic Obstructive Pulmonary Disease Care
     - iv. ☒ CIP Congestive Heart Failure
     - v. ☒ CIP Chronic Hypertension Care
     - vi. ☒ CIP Post MI or Cardiac Intervention Care
     - vii. ☐ CIP Post Orthopedic Surgery Care
     - viii. ☒ CIP Post Stroke Care
     - ix. ☐ CIP Prenatal Care
     - x. ☐ CIP Mom/Baby Postpartum Care

xi. ☐ CIP Sleep Apnea Care

xii. ☐ CIP Wound Care

xiii. ☐ CIP Substance Use Disorder Care

xiv. ☐ CIP Skin Rash Complaints

xv. ☐ CIP Urinary Complaints

xvi. ☐ CIP Gastrointestinal Complaints

xvii. ☐ CIP Lower Respiratory Infection Complaints

xviii. ☐ CIP Sore Throat and Upper Respiratory Complaints

xix. ☐ CIP Nontraumatic Nosebleed Complaints

3. Procedure protocols
   a. Will include:
      i. CIP Fall Risk Reduction Assessment
      ii. CIP SDOH Assessment
      iii. CIP Medication Audit
   b. May include:

i. ☐ CIP Community Outreach Provider Visit

ii. ☐ CIP Feeding Tubes

iii. ☐ CIP Urinary Catheters

iv. ☐ CIP Ostomies

v. ☐ CIP Nasal Packing

vi. ☒ CIP Specimen Collection

vii. ☒ CIP Point of Care Testing for Blood Analysis

viii. ☒ CIP Suture Removal

ix. ☐ CIP Otoscope

x. ☒ CIP PICC Access

xi. ☒ CIP Vaccinations

xii. ☐ CIP Naloxone Leave Behind

Purpose: To provide guidance for documentation of CIP services

I. Patient contacts will be documented in an EPCR system including:
   a. Face to face contact with or without treatments rendered
   b. Telephone/telehealth contact
II. Communications with all persons regarding a patient will be documented in an EPCR system. Examples include but are not limited to:
   a. Licensed health care providers
      i. Communications with licensed health care providers that influence the route of care (receiving an order from or reporting an issue to) should include name, agency, date, time and issue relayed to provider.
   b. Family members
   c. Social service organizations
   d. Meals on wheels
   e. Volunteer organizations
   f. Community organizations
III. EPCRs will be available to the referring physician within 24 hours of the completion of the visit. Transmission of electronic records will be determined by MCA.
IV. Things that cannot be documented directly into the EPCR will be attached to the EPCR. This includes but is not limited to forms and checklist that are not housed within the EPCR such as:
   a. Consent forms
   b. Physician created care plans
   c. Checklists
   d. Medication lists
   e. Physician's orders
V. Procedure protocol documentation will include:
   a. Evaluation findings
   b. Interventions
   c. Response to interventions (Results may be improved, unchanged, or worsened)

CIP PROGRAM ENROLLMENT

Initial Date: July 23, 2020
Revised Date: Section 11-06

Purpose: To provide guidelines for patient enrollment into Community Integrated Paramedicine Programs.

I. Enrollment to a CIP program will be necessary in the following situations:
   a. A physician's referral
   b. Anticipation of more than 1 visit (includes but not limited to phone, telehealth/telemedicine, in person).
II. Enrollment will include:
   a. Physician's referral (physician name should be documented in EPCR)
   b. Documented patient consent
   c. Documented intake assessment including but not limited to:
      i. Physical assessment with notation to overall physical and mental statuses and limitations both physical and cognitive
      ii. Fall risk reduction assessment **see Fall Risk Reduction Assessment protocol**
      iii. Social determinants of health assessment **see SDOH Assessment protocol**
      iv. Medication audit **see Medication Audit protocol** (optional)
   d. Development of a service plan/care plan
III. Patient enrollment including the intake assessment must be documented within the EPCR or attached to the EPCR
IV. Whenever possible CIP services should work in conjunction with already established services available within the community.

CIP PATIENT SERVICE PLAN/CARE PLAN

Initial Date: July 23, 2020
Revised Date:
Section 11-07

Purpose: To outline the minimum elements that must be included in a service plan/care plan for patient's enrolled in CIP programs.

I. The CIP patient service plan/care plan will include (if applicable):
   a. Short and long-term health care needs and goals including timeframes for meeting the goals (including end of life care).
   b. A description of the out-of-hospital services needed to address and satisfy the patient's needs and goals.
   c. Frequency of visits and projected number of visits.
   d. A goal for the patient's discharge
   e. Medications administered
   f. Medication audits performed and findings
   g. Prescriptions provided
   h. Decline in physical or mental health
   i. Decline in mobility or capacity for self-care
   j. Change in environment or person's residing within the environment
   k. Admission to a hospital
   l. Medications or treatment rendered
   m. Unscheduled or episodic care provided by the CIP program
   n. Clinic or physician follow up schedule and logistics for follow up compliance if indicated.

II. The CIP patient service plan/care plan will be updated upon each visit.

III. The CIP service plans/care plan must be documented within the EPCR or attached to the EPCR.

CIP PROGRAM DISCHARGE

Initial Date: July 23, 2020
Revised Date: Section 11-08

Purpose: To provide guidelines for patient discharge or disenrollment from a Community Integrated Paramedicine Program.

Aliases: Dis-enrollment, graduation

I. Planned Discharges
   a. Goals met and physician discharges
   b. Expirations of physician's order
   c. Referral to higher level of care

II. Unplanned Discharges
   a. Cancelation/missing more than 3 visits without notice or valid cause
   b. Non-adherence to goals
   c. Relocation
   d. Patient/family request
   e. Unsafe situation for the CIP provider
   f. Death

III. Discharge documentation will include:
   a. How and when the patient was informed
   b. How and when the ordering physician was informed
   c. Health status upon last visit
   d. Concerns of discontinued care
   e. Persons informed of concerns

IV. Discharges must be documented within the EPCR or attached to the EPCR.