



Purpose: This Mobile Integrated Health (MIH) Data Collection Guide has been developed to provide extended guidance to EMS agencies and vendors for the documentation and submission of data for MIH encounters to the EMSTARS repository. This document has been prepared in collaboration with the Office of Mobile Integrated Health, the EMS Data Unit, Bureau of Emergency Medical Oversight, and representatives of the Emergency Medical Services Advisory Council Data Committee.

Submission Policy Guidelines: The following submission guidelines are applicable to all licensed EMS agencies in the state of Florida.

1. **All MIH encounters must be reported to EMSTARS:**

- MIH encounters are considered EMS events, regardless of the system used to document them.
- Data on EMS events, including MIH visits, may be collected in multiple systems. It is not within the scope, nor the intent, of the state to dictate which systems can or should collect this data. However, it is the intent that information be reported to the statewide EMSTARS system as an EMS event regardless of which system was used to initially capture it.
 - Where multiple systems are utilized to capture information on EMS events, a participating agency must determine whether to pursue system integration or require crews to enter the required information in the separate systems. Each agency must evaluate its needs and its resources and determine the best solution for its operations.
- It does not matter how the event records are transmitted to the EMSTARS system; they could be exported from one system or combined into a single export from multiple sources. The only requirement is that event records are sent, with the required information included, based on the XML schema definitions provided by the Florida EMS Data Dictionary. Again, the MIH data requirements are minimized for submission.

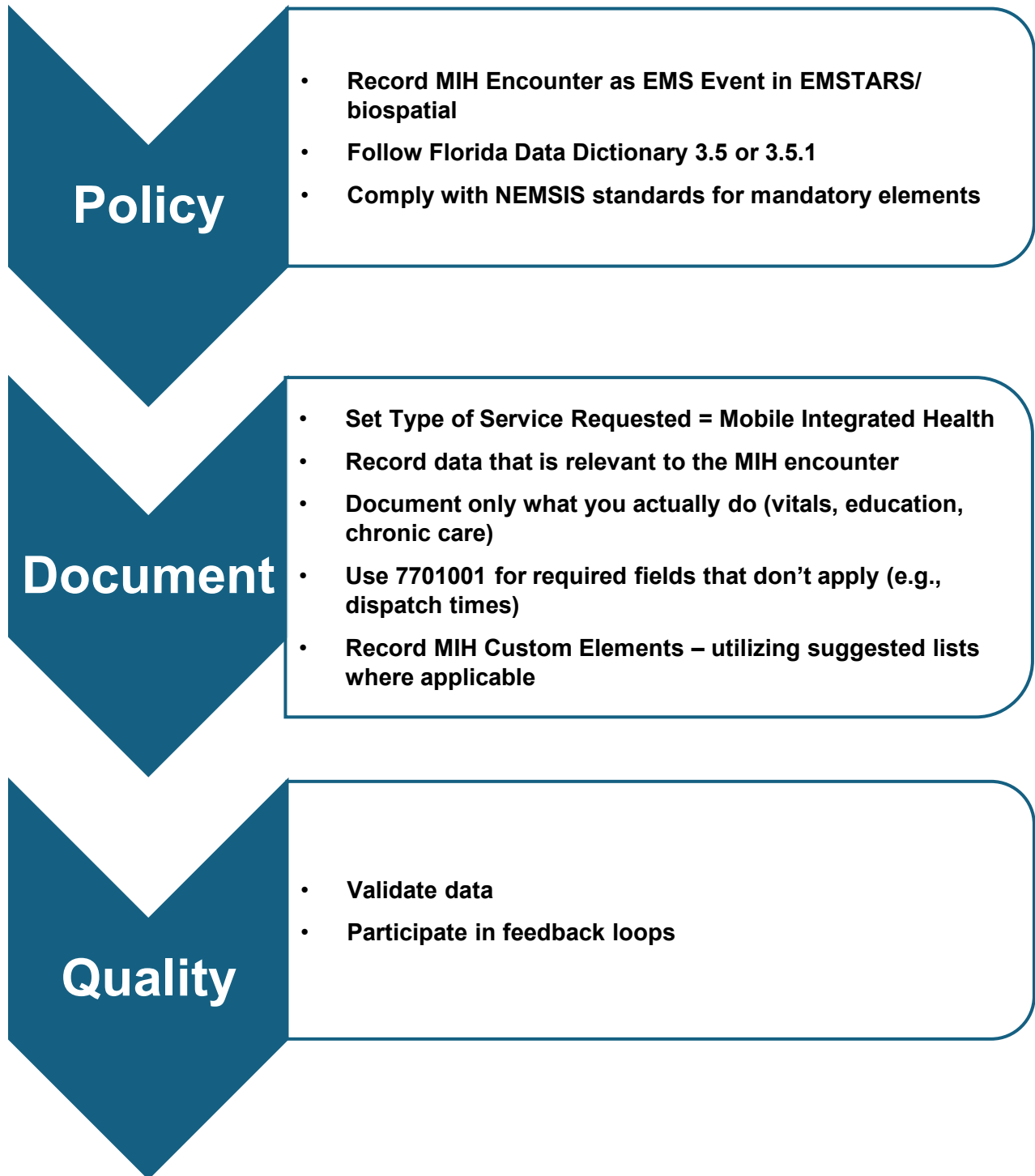
2. **Florida's EMSTARS data standard follows NEMSIS v3 usage levels (Mandatory, Required, Recommended, Optional):**

- "Mandatory" elements must be present and never accept NOT values.
- "Required" elements must be present but may use NOT values such as **7701001 (Not Applicable)** when an item truly doesn't apply.
- Conditional elements: may be present; if present but not applicable, you may use **7701001**. "Optional" elements can be omitted.

3. **Florida Schematron rules:**

- There is **one rule set**, but it uses conditional logic. The Florida Schematron is being reviewed to identify potential modifications related to emergent and non-emergent MIH encounters.

MIH Data Submission Process Overview: The following graphic represents the general best practice process flow for documenting an MIH encounter:



MIH Data Element Submission Overview: Below is a table representation of the MIH documentation guidelines for a planned MIH visit scenario (no dispatch, no transport), and a MAT scenario. The practical minimum dataset can vary based on whether it's an intake or subsequent visits as well as the actual MIH services being provided so it's difficult to state exactly the "minimum" data set. However, we can provide the following representative data element inclusion guidance.

Element Name	Element Number	Planned MIH Visit – General Scenario	Planned MIH Visit – MAT Scenario
Patient Care Report Number	eRecord.01	NEMSIS Mandatory	NEMSIS Mandatory
Software Creator	eRecord.02	NEMSIS Mandatory	NEMSIS Mandatory
Software Name	eRecord.03	NEMSIS Mandatory	NEMSIS Mandatory
Software Version	eRecord.04	NEMSIS Mandatory	NEMSIS Mandatory
Dispatch Reason	eDispatch.01	<p>NEMSIS Mandatory</p> <p>Several field values could be used.</p> <p>If no value is appropriate use 2301051 – No other appropriate choice</p>	<p>NEMSIS Mandatory</p> <p>Generally, this is not done through dispatch and is generally non-emergency</p> <p>If it comes through dispatch, several values may be applicable so pick the most appropriate</p> <p>The following codes may apply:</p> <p>2301075 – Well Person Ck 2301061 – Sick Person 2301053 – Overdose/Poisoning/Ingestion 2301051 – No other appropriate choice</p>
EMS Agency Number	eResponse.01	NEMSIS Mandatory	NEMSIS Mandatory
Incident Number	eResponse.03	<p>Florida Mandatory</p> <p>Use incident number provided by Dispatch or use 7701001 Not Applicable if this encounter did not initiate through dispatch</p>	<p>Florida Mandatory</p> <p>Use incident number provided by Dispatch or use 7701001 Not Applicable if this encounter did not initiate through dispatch</p>

Element Name	Element Number	Planned MIH Visit – General Scenario	Planned MIH Visit – MAT Scenario
Type of Service Requested	eResponse.05	NEMSIS Mandatory 2205031 Mobile Integrated Health Care Encounter	NEMSIS Mandatory 2205031 Mobile Integrated Health Care Encounter
Unit Transport and Equipment Capability	eResponse.07	NEMSIS Mandatory Choose the most appropriate field value	NEMSIS Mandatory Choose the most appropriate field value
EMS Vehicle Number	eResponse.13	NEMSIS Mandatory For normal encounter visits, this is recommended to be the State Vehicle Permit If the vehicle is not licensed by the state, it can be same as EMS Unit Call Sign If the encounter is a phone call or virtual call, use EMS Unit Call Sign also	NEMSIS Mandatory For normal encounter visits, this is recommended to be the State Vehicle Permit If the vehicle is not licensed by the state, it can be same as EMS Unit Call Sign If the encounter is a phone call or virtual call, use EMS Unit Call Sign also
EMS Unit Call Sign	eResponse.14	NEMSIS Mandatory Record the normal Unit Call Sign	NEMSIS Mandatory Record the normal Unit Call Sign
Response Mode to Scene	eResponse.23	NEMSIS Mandatory Generally, this will be non-emergent 222305	NEMSIS Mandatory Generally, this will be non-emergent 222305 Can be changed if situation becomes emergent, then use 2223007 Non-emergent Upgraded to Emergent
Unit Disposition	eDisposition.27	NEMSIS Mandatory Can be any of the values to indicate a scheduled/ non-emergent encounter and “Patient Contact Made” (with no transport as applicable)	NEMSIS Mandatory Can be any of the values to indicate a scheduled/ non-emergent encounter and “Patient Contact Made” (with no transport as applicable)
Patient Evaluation/ Care	eDisposition.28	Can be any of the values	Can be any of the values

Element Name	Element Number	Planned MIH Visit – General Scenario	Planned MIH Visit – MAT Scenario
Crew Disposition	eDisposition.29	Can be any of the values	Can be any of the values
Transport Disposition	eDisposition.30	Generally, there is no transport, but any code can be used No Transport – 423001	Generally, there is no transport, but any code can be used No Transport – 423001 unless changed to transport on scene
Unit Notified by Dispatch Date/Time	eTimes.03	NEMESIS Mandatory If encounter did not come through dispatch, use the date/time that unit started to the encounter	NEMESIS Mandatory If encounter did not come through dispatch, use the date/time that unit started to the encounter
Unit Arrived on Scene Date/Time	eTimes.06	Record date/time arrived at encounter location	Record date/time arrived at encounter location
Arrived at Patient Date/Time	eTimes.07	Record date/time arrived at encounter patient	Record date/time arrived at encounter patient
Unit Left Scene	eTimes.09	Record when you left scene of encounter	Record when you left scene of encounter
Unit Back in Service Date/Time	eTimes.13	NEMESIS Mandatory Record when back in service and available	NEMESIS Mandatory Record when back in service and available
Unit Canceled Date/Time	eTimes.14	Record if encounter is canceled prior to arriving at patient	Record if encounter is canceled prior to arriving at patient
Patient Demographic	ePatient elements that can be collected ePatient.1 – ePatient.25	(Name/DOB/sex, home address if pertinent), plus payer/coverage if you collect billing (Florida uses v3.5.1 “Patient’s Sex” and deprecates the older gender element)	(Name/DOB/sex, home address if pertinent), plus payer/coverage if you collect billing (Florida uses v3.5.1 “Patient’s Sex” and deprecates the older gender element)
Scene	eScene.11 eScene.15 17,18,19	Scene GPS, location or address, city, county, state, zip	Scene GPS, location or address, city, county, state, zip

Element Name	Element Number	Planned MIH Visit – General Scenario	Planned MIH Visit – MAT Scenario
Situation Assessment Appropriate to MIH	eSituation.09	Primary Symptom	Primary Symptom
	eSituation.10	Other associated symptoms	Other associated symptoms
	eSituation.11	Primary Impression	Primary Impression
	eSituation.12	Secondary Impression	<p>Secondary Impression</p> <p>Need to check to see if there any ICD-10 codes specific to MAT – examples</p> <p>Document the patient's opioid-related diagnosis:</p> <p>F11.20 – Opioid dependence, uncomplicated F11.21 – Opioid dependence, in remission F11.22 – Opioid dependence with intoxication F11.23 – Opioid dependence with withdrawal F11.24–F11.29 – Opioid dependence with induced disorders (e.g., mood, sleep, sexual dysfunction) F11.10–F11.19 – Opioid abuse (with similar sub-classifications) F11.90–F11.99 – Opioid use, unspecified (with similar sub-classifications)</p> <p><u>Long-Term Opioid Use</u> Z79.891 – Long-term (current) use of opiate analgesic (for maintenance medication, excluding methadone maintenance)</p>

Element Name	Element Number	Planned MIH Visit – General Scenario	Planned MIH Visit – MAT Scenario
Additional Assessment Appropriate to MIH Initial Patient Acuity Final Patient Acuity	eSituation.13 eDisposition.19	Initial patient acuity and final patient acuity are recommended to assess impact of MIH encounter	Initial patient acuity and final patient acuity are recommended to assess impact of MIH encounter
Clinical Content Appropriate to MIH Goals		Document only what you performed/assessed	Document only what you performed/assessed
	eHistory	(Meds, allergies, med/surg history, advanced directives, care barriers) as applicable	(Meds, allergies, med/surg history, advanced directives, care barriers) as applicable
	eVitals	At least one set of vitals for the visit (BP/HR/RR/SpO2/temp as applicable) Stroke/trauma scores are not needed unless clinically relevant	At least one set of vitals for the visit (BP/HR/RR/SpO2/temp as applicable) Stroke/trauma scores are not needed unless clinically relevant
	eExam	Any findings when exam is completed	Any findings when exam is completed
	eProcedures/ eMedications	If you performed any interventions (e.g., med reconciliation isn't a medication "administered", but education/care plan updates can be captured in narrative or custom fields depending on your software)	Confirm procedure list and provide examples Confirm medication list and provide examples
Patient Care Report Narrative	eNarrative.01	Any program-specific fields your MIH module collects (SDOH screening, care plan, referrals) (Florida validates state datasets and custom elements via the same process)	Any program-specific fields your MIH module collects (SDOH screening, care plan, referrals) (Florida validates state datasets and custom elements via the same process)

Florida Custom Elements

Element Name	Element Number	Planned MIH Visit - General Scenario	Planned MIH Visit - MAT Scenario
Patient Identifier	CP_MIH_02	This number should remain the same for the patient throughout the patients care regardless of number of visits	This number should remain the same for the patient throughout the patients care regardless of number of visits
Referral in Source	CP_MIH_10	Field values provided in DD	Field values provided in DD
MIH Visit Type/Stage	CP_MIH_13	Field values provided in DD	Field values provided in DD
Factors Influencing Health Status/Barriers to Care (SDOC)	CP_MIH_29	Factors influencing health status and contact with health services, ICD-10 (Z,R,F,H) initial suggested code list provided	Factors influencing health status and contact with health services, ICD-10 (Z,R,F,H) initial suggested code list provided
Military Service	CP_MIH_30	Field values provided in DD	Field values provided in DD
VA Benefits/ Services	CP_MIH_31	Field values provided in DD	Field values provided in DD
MIH Services Provided	CP_MIH_35	Field values provided in DD	9010002 – Medication assistance treatment - MAT
Telehealth Used on Scene	ceTelehealth	Yes or No or 7701001 Not Applicable	No
Visit Method Type	ceVisitMethod Type	In Person, Virtual, Phone or not applicable	In Person
Resource Connections	ceResource Connections	Field values provided in DD, use other if not on list and notify program office to potentially add to value list	Field values provided in DD, use other if not on list and notify program office to potentially add to value list

Suggested Codes for Factors influencing health status – CP_MIH_29: During MIH encounters, “factors influencing health status” or social determinants of health are assessed to determine the needs of patient. ICD-10 (Z,R,F,H) codes are used to capture this information. The following table has categorized these by the typical assessment areas and identified suggested codes for your use. This is not intended to be a complete list but rather the most common code used.

Area of Assessment	Suggested Z-Code List
Education Level	<p>Z55.0 – Illiteracy and low-level literacy Z55.1 – Schooling unavailable and unattainable Z55.5 – Less than a high school diploma Z55.6 – Problems related to health literacy (includes difficulty understanding health information, medication instructions, or completing medical forms) Z55.8 – Other problems related to education and literacy Z55.9 – Problems related to education and literacy, unspecified (for general or non-specific educational issues, e.g., academic problems)</p>
Living Situations	<p>Z59.00 – Homelessness, unspecified Z59.01 – Sheltered homelessness (living in shelters) Z59.02 – Unsheltered homelessness (living on streets, cars, etc.) Z59.10 – Inadequate housing, unspecified Z59.11 – Inadequate housing environment temperature (lack of air conditioning, heating due to housing conditions) Z59.12 – Inadequate housing utilities (lack of electricity, gas, oil, water due to housing conditions) Z59.3 – Problems related to living in residential institution Z59.811 – Housing Instability, housed, with risk of homelessness Z59.812 – Housing Instability, housed, homelessness in past 12 months Z59.819 – Housing instability, housed unspecified (use when reason or type of instability is unknown) Z59.861 – Financial insecurity, difficulty paying for utilities (e.g., electricity, heat, oil, water, disconnect notice due to inability to pay) Z59.89 – Other problems related to housing and economic circumstances (e.g., cluttered or unsafe home, isolated dwelling, lack of privacy or overcrowded) Z59.9 – Problem related to housing and economic circumstances, unspecified (most general code when nature of the problem is not specified)</p>
Employment	<p>Z56.0 – Unemployment, unspecified Z56.1 – Change of job Z56.2 – Threat of job loss Z56.3 – Stressful work schedule Z56.6 – Other physical and mental strain related to work Z56.89 – Other problems related to employment (not elsewhere classified) Z56.9 – Unspecified problems related to employment</p>

Area of Assessment	Suggested Z-Code List
Food Insecurity	<p>Z59.41 – Food insecurity (e.g., skipping meals due to cost, relying on food banks, chronic, worried about quantity of food)</p> <p>Z59.48 – Other specified lack of adequate food (e.g., available food is not appropriate for diet, inadequate food quality, potentially acute)</p>
Medication Access	<p>Z91.120 – Patient’s intentional underdosing of medication due to financial hardship</p> <p>Z91.128 – Patient’s intentional underdosing of medication for other reason (e.g., distrust of medication, nonadherence without a specified motive)</p> <p>Z91.130 – Patient’s unintentional underdosing of medication regimen due to age-related debility</p> <p>Z91.141 – Patient’s other noncompliance with medication regimen</p>
Health Care Access	<p>Z59.71 – Insufficient health insurance coverage (e.g., no, inadequate, or insufficient health insurance)</p> <p>Z75.0 – Medical services not available in home (e.g., no home health agency, lack of or infeasible to have medical equipment in the home)</p> <p>Z75.3 – Unavailability and inaccessibility of health care facilities (use when a needed health care facility does not exist in the area, is not accessible due to barriers, is unable to accept patients, or when patient cannot reach a facility providing appropriate level of care)</p> <p>Z75.4 – Unavailability and inaccessibility of other helping agencies (e.g., community resources, social service agencies, support programs, other non-health care assistance)</p>
Fall Risk	<p>Z91.81 – History of falling</p>
Caregiver	<p>Z60.2 – Problems related to living alone (use when it affects treatment planning, increases risk, provider documents lack of informal support, or impacts follow-up or adherence)</p> <p>Z74.2 – Need for assistance at home and no other household member able to render care</p> <p>Z74.8 – Other problems related to care provider dependency (use when intermittent support is needed for non-medical reasons such as transportation, shopping, meal preparation)</p> <p>Z74.9 – Problem related to care provider dependency, unspecified (use when details are unclear but dependency is documented)</p>
Mobility	<p>Z74.01 – Bed confinement status (indicates the patient is confined to bed)</p> <p>Z74.09 – Other reduced mobility (use when patient has limited mobility, but documentation has vague reasons such as due to chronic illness, weakness, needs assistance when walking)</p>
Ability to Perform Self Care	<p>Z74.1 – Need for assistance with personal care (use when the patient requires help with activities of daily living (ADLs) like bathing, dressing, eating)</p>

Area of Assessment	Suggested Z-Code List
Ability to Perform Usual Activities	<p>Z73.6 – Limitation of activities due to disability (use when a patient’s usual activities are restricted because of a disability)</p> <p>Z73.89 – Other problems related to life management difficulty (use when documentation names a clear issue limiting daily life activities)</p> <p>Z73.9 – Problem related to life management difficulty, unspecified (use not when daily life activities are limited but no clear issue is documented)</p> <p>Z74.3 – Need for continuous supervision (use when continuous supervision is required to prevent harm, manage confusion, or ensure adherence to essential care)</p>
Poverty	<p>Z59.5 – Extreme poverty (e.g., destitute, patient living in severe poverty conditions)</p> <p>Z59.6 – Low income (income level is insufficient but not classified as extreme poverty)</p> <p>Z59.72 – Insufficient welfare support (e.g., denied, reduced or lapsed benefits, insufficient coverage for essential needs, inability to access welfare needs)</p> <p>Z59.868 – Other specified financial insecurity (e.g., bankruptcy, burdensome debt, unable to make ends meet)</p> <p>Z59.869 – Financial insecurity, unspecified (use when reason or type of financial insecurity is not specified)</p> <p>Z59.87 – Material hardship due to limited financial resources, not elsewhere classified (e.g., due to limited resources unable to attain childcare, clothing, basic needs)</p>
Other Social Determinants of Health (SDOH)	<p>Z75.3 – Unavailability and inaccessibility of health care facilities (use when a patient cannot access care (including telehealth) due to lack of internet or connectivity)</p> <p>Z59.82 – Transportation insecurity (e.g., lack of, inadequate, unaffordable, inaccessible, excessive transportation time)</p>
Pain or Discomfort	<p>R52.0 – Acute pain</p> <p>R52.1 – Chronic pain</p> <p>R52.2 – Other chronic pain</p> <p>R52.9 – Pain, unspecified</p> <p>R68.89 – Other general symptoms and signs (use when discomfort is non-specific and not tied to a particular organ system)</p> <p>R45.89 – Other symptoms and signs involving emotional state if discomfort is psychological or emotional in nature</p>
Anxiety or Depression	<p>F40.00 – Agoraphobia, unspecified</p> <p>F40.01 – Agoraphobia with panic disorder</p> <p>F40.02 – Agoraphobia without panic disorder</p> <p>F40.10 – Social phobia, unspecified</p> <p>F40.11 – Social phobia, generalized</p> <p>F40.2x – Specific (isolated) phobias, e.g., F40.218 Arachnophobia</p> <p>F41.0 – Panic disorder, unspecified or without agoraphobia</p> <p>F41.1 – Generalized anxiety disorder (GAD)</p> <p>F41.2 – Mixed anxiety and depressive disorder</p> <p>F41.3 – Other mixed anxiety disorders</p> <p>F41.8 – Other specified anxiety disorders</p> <p>F41.9 – Anxiety disorder, unspecified (billable)</p>

Area of Assessment	Suggested Z-Code List
	<p><u>Major Depressive Disorder – Single Episode (F32.x)</u> F32.0 – Mild F32.1 – Moderate F32.2 – Severe without psychotic features F32.3 – Severe with psychotic features F32.4 – In partial remission F32.5 – In full remission F32.8 – Other specified F32.9 – Unspecified F32.A – Depression, unspecified (new code effective Oct 2025)</p> <p><u>Major Depressive Disorder – Recurrent (F33.x)</u> F33.0 – Mild F33.1 – Moderate F33.2 – Severe without psychotic features F33.3 – Severe with psychotic features F33.4 – In remission F33.8 – Other specified F33.9 – Unspecified</p> <p><u>Persistent Mood Disorders (F34.x)</u> F34.1 – Dysthymia (persistent depressive disorder) F34.8 – Other specified persistent mood disorders F34.9 – Unspecified persistent mood disorder</p>
Disabilities Reported Among MIH Patients	<p><u>Physical Disabilities</u> Z74.09 – Other reduced mobility Z74.01 – Bed confinement status Z99.3 – Dependence on wheelchair Z99.81 – Dependence on supplemental oxygen</p> <p><u>Intellectual & Developmental Disabilities</u> F70–F79 – Intellectual disabilities F70 – Mild F71 – Moderate F72 – Severe F73 – Profound F78 – Other F79 – Unspecified F84.x – Autism spectrum disorders</p> <p><u>Sensory Disabilities</u> H54.x – Blindness and visual impairment H91.x – Hearing loss R48.x – Dyslexia and other symbolic dysfunctions</p> <p><u>Speech & Language Disabilities</u> R47.x – Speech disturbances (e.g., aphasia, dysarthria)</p>

Additional Notes for MAT Scenario – MAT treatment can be captured under the following:

- MAT treatment and information left behind can be captured with **CP_MIH_35: CP/MIH Service Provided**
 - **9010002** Medication Assistance Treatment (MAT)
 - **9010029** Reducing Mental Health-Related Recidivism: Addiction/Overdose
 - Other more applicable codes

- Referral to recovery could be captured under **ceResourceConnections**
 - **9030003** Mental/Behavioral Health (or any of the other codes that are more applicable)

- If Narcan is administered, it can be documented under Medications Administered
 - Naloxone (or most appropriate RxNum)