

APPENDIX

SECTION 1 – PLAN TO PLAN

1.1 COMMUNITY PARAMEDICINE RESOURCES

1.2 DEFINITIONS

1.3 WORKPLAN

SECTION 2 – ASSESS PROGRAM FEASIBILITY

NONE

SECTION 3 – COMMUNITY NEEDS

NONE

SECTION 4 – DETERMINE MEDICAL DIRECTION

4.1 SAMPLE MEDICAL DIRECTOR TALKING POINTS

SECTION 5 – PLAN & IMPLEMENT EDUCATION

NONE

SECTION 6 – DETERMINE PROGRAM SCOPE

- 6.1 LIST OF POSSIBLE PROGRAM SERVICES
- 6.2 CP JOB DESCRIPTION
- 6.3 SAMPLE MEDICAL DIRECTOR AGREEMENT
- 6.4 THE RIGHT COMMUNITY PARAMEDIC STUDENT
- 6.5 PROFORMA BUDGET

SECTION 7 – ENGAGE THE COMMUNITY & STAKEHOLDERS

- 7.1 – SAMPLE COMMUNITY MEETING AGENDA
- 7.2 – SAMPLE STAKEHOLDER ENGAGEMENT FORUM AGENDA
- 7.3 – LIST OF PEOPLE TO ENGAGE
- 7.4 – SAMPLE TALKING POINTS

SECTION 8 – DEVELOP POLICES & PROCEDURES

- 8.1 – REFERRAL FORM
 - 8.2 – CP CONSENT FORM
 - 8.3 – HOME SAFETY ASSESSMENT
 - 8.4 – PHQ2
 - 8.5 – PHQ9
 - 8.6 – DISCHARGE SUMMARY
 - 8.7 – ECPS POLICY AND PROCEDURE
 - 8.8 – ECPS COMMUNITY PARAMEDIC PROTOCOLS WINTER 2018
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8.9 – COMMUNITY PARAMEDIC CQI FORM

SECTION 9 – DEVELOP A DATA COLLECTION PROCESS

9.1 – CP PATIENT DATA TEMPLATE

SECTION 10 – BEGIN OPERATIONS

10.1 – REFERRAL FORM

10.2 – SAMPLE PATIENT CARE CHART/REPORT

10.3 – MOU SAMPLE AND IGA SAMPLE

10.4 – PATIENT CHRONOLOGY SAMPLE

SECTION 11 – DEVELOP A PLAN TO EVALUATE & USE PROGRAM DATA

11.1 – ROI WORKBOOK

11.2 – COMMUNITY PARAMEDIC CQI FORM

11.3 – SAMPLE PATIENT SURVEY

11.4 – MIH METRICS

SECTION 12 – EVALUATE THE PROGRAM

12.1 – SAMPLE PATIENT SURVEY

PLAN TO PLAN

APPENDIX 1

SECTION 1 – PLAN TO PLAN

1.1 COMMUNITY PARAMEDICINE RESOURCES

1.2 DEFINITIONS

1.3 WORKPLAN

Appendix 1.1 List of Resources

Community Paramedicine® Resources

Additional information and connections to national organizations, literature and other resources are provided below.

- **International Roundtable on Community Paramedicine:** www.IRCP.org

- **Joint Committee on Rural Emergency Care:**
National Association of State EMS Officials & National Organization of State Offices of Rural Health
 - Policy Brief on Integration of EMS into the Healthcare Delivery System, November 2009: https://nosorh.org/policy/files/jcrec_policy_brief.pdf

 - State Perspectives: Discussion Paper on Development of Community Paramedic Programs, 2010:
<https://nasemso.org/wp-content/uploads/CPDiscussionPaper.pdf>

- **Community Paramedic Curriculum:** www.communityparamedic.org/Colleges.aspx

- **The Paramedic Foundation:** <http://paramedicfoundation.org/Innovation>

- **Rural Health Hub:** <https://www.ruralhealthinfo.org/topics/community-paramedicine#models>

- **Eagle County Paramedics Community Paramedic Program Development:**
 - Chris Montera, Chief
Eagle County Health Services District, Eagle County Paramedics
E-mail: cmontera@ecparamedics.com
Website: www.eaglecountyparamedics.com/community-paramedic/

 - Anne Montera, BSN, RN, President
Caring Anne Consulting, LLC, Public Health Nurse Consultant
E-mail: anne@caringanne.com

Appendix 1.2 Definitions Page

CDPHE – Colorado Department of Public Health and Environment

CP – Community Paramedicine (or Community Paramedic): Programs operated by EMS agencies using people and systems normally regulated by a state EMS office. Programs focus on reducing hospital and EMS utilizations for patients who have been deemed either high utilizers of the EMS system in the past or have been recognized as a possible vulnerable patient by a healthcare provider including but not limited to medically underserved, low-income, mental health, intellectually disabled and geriatric populations. This is achieved through a combination of advocating for the patient, patient education and assistance navigating through the healthcare and social services industries in an efficient and timely fashion with the goal of financially impacting the healthcare system and medically impacting the patient.

MIH – Mobile Integrated Healthcare: The provision of healthcare using patient-centered, mobile resources in the out-of-hospital environment. Agencies that are not EMS agencies and are using a variety of healthcare providers normally regulated elsewhere in a state health department. It may include services such as providing telephone advice to 9-1-1 callers instead of resource dispatch; chronic disease management, preventive care or post-discharge follow-up visits; or transport or referral to a broad spectrum of appropriate care, not limited to hospital emergency departments.

“Community Paramedic Toolkit”. The definition of a “toolkit” used during the search included a *“set of tools designed together for a particular purpose or function.”*

Emergency Medical Services (EMS)
Emergency Medical Technicians (EMTs)
Advanced Emergency Medical Technicians (AEMTs)

Telephone Redirection: Utilizing a call center to redirect non-emergent calls to the appropriate destination or provider

Integration: Working closely to collaborate with other organizations or providers; the process of integrating

Health Promotion: The science and art of helping people change their lifestyle to move toward a state of optimal health

Safety Inspection: An organized examination or formal evaluation to ensure a safe environment or safe practices.

Community Paramedics as a Safe Practitioner: A Paramedic that has advanced education and is safe in every aspect of the care they deliver

Treat and Release: Treatment rendered at time of call and then the patient is safely left in their environment without need for transport to an emergency center.

Paramedic Operating in Primary Care: Paramedics providing primary care services within their scope of practice in conjunction with a well-coordinated care plan.

Policy: A high-level overall plan embracing the general goals and acceptable procedures

Value: The measure of outcomes and/or economic benefit utilizing innovative or transformative methods of care

Emergency Department Visit Reduction: Treatment or care of patients that work towards minimizing the use of emergency departments in hospitals

Assessment and Referral: The process of evaluating the physical, mental, or social need of a patient and then referring them to an appropriate resource to assist with improving outcomes

APPENDIX 4

DETERMINE MEDICAL DIRECTION

4.1 SAMPLE MEDICAL DIRECTOR TALKING POINTS



WESTERN EAGLE COUNTY

HEALTH SERVICES DISTRICT

785 Red Table Dr
Gypsum, CO 81637

P: 970-524-1689

F: 970-524-1771

Community Paramedic Medical Provider Talking Points

Opportunity Statement

- CP visits can benefit high utilizers of the system
- CPs can see low acuity visits such as blood draws, oxygen saturation checks, ear checks, wound checks, and medication reconciliation
- CP can be the eyes and ears of the physicians in the patient's home
- CP visits can assist home bound patients that don't qualify for Home Care or Hospice
- CP visits can emphasize managing chronic illness (CHF, Asthma, Pneumonia, MI, etc)
- CPs can assist with health promotion and wellness activities
- CPs can provide preventative services such as flu shots, home safety inspections, and fall risk assessments
- CPs can link patients to community resources and services to assist in providing collaborative care (public health, social services, economic resources, etc)
- CPs can assist with the large percentage of patients that delay accessing health services within the system until it is too late

Hospital Discharge Follow-up

- Visit will occur within 48 hours after discharge
- CPs can assist with link the patients with their Primary Care Provider (PCP) or help patients find a PCP that don't already have one
- CPs can see patients in a timely manner especially if patients can't get in to see their PCPs within 48 hours after discharge
- CPs are the link to communicate the patient's status between the hospital and the PCP
- CPs can conduct in home Medication Reconciliation, confirming the exact medications the patient's are currently taking at home
- CPs can revisit hospital discharge instructions with the patient and conduct a comprehensive pain assessment.

How Does it Work?

1. Identify a patient that could benefit from the program
2. The PCP refers the patient using the physician referral form (attached)
3. Fax the patient referral to the Community Paramedic Coordinator at **970-524-1771**
4. The CP Coordinator will contact the patient and schedule the visit based on the referral
5. The CP will provide the services in the home that are within their current scope of practice including: hospital discharge follow-up, home safety inspection, blood draws, oxygen saturation checks, medication reconciliation or wound care.
6. The CP will then communicate and fax health records back to the referring physician and PCP to ensure quality of care and appropriate oversight.

Community Focused Emergency Medical Services

www.wecadems.com

APPENDIX 6

DETERMINE PROGRAM SCOPE

6.1 LIST OF POSSIBLE PROGRAM SERVICES

6.2 CP JOB DESCRIPTION

6.3 SAMPLE MEDICAL DIRECTOR AGREEMENT

6.4 THE RIGHT COMMUNITY PARAMEDIC STUDENT

6.5 PROFORMA BUDGET

Job Title: **Community Paramedic**

Reports To: **<<Report Title>>**

Prepared Date: **<<Date>>**

Position Summary

A Community Paramedic connects underutilized resources to underserved populations. It is an expansion of the role of the paramedic to provide health services where access to physicians, clinics, and/or hospitals is difficult or may not exist. The role exists for the sole purpose of serving the needs of the community and its success relies heavily on collaboration among local stakeholders.

General Duties and Responsibilities

- Performs all primary job responsibilities listed for a Paramedic.
- Examines, screens, treats and coordinates health services for patients.
- Conducts post-hospital release follow-up care, including but not limited to, monitoring medication, dressing changes, and checking vital signs.
- Observes, records, and reports to physicians, patient's conditions and reactions to drugs, treatments, and significant incidents.
- Conducts patient education, including diabetes prevention/treatment, hypertension, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), falls assessment, injury evaluation, geriatric frailty visits and nutrition.
- Administers patient care consistent with department protocols and physician orders.
- Coordinates appointments and follow-up with physicians and hospitals.
- Develops and completes appropriate reports and templates for the CP Program.
- Attends meetings as requested and available.
- Other duties as assigned.

Supervisory Responsibilities

Enter job titles this position will supervise and then delete this line.

Requirements

- Associate's Degree required. Bachelor's Degree preferred.
- Minimum of 5 years EMS experience with at least 3 years as a paramedic.
- Training, CQI, marketing and/or public information experience helpful.
- Professionalism and ability to be discreet with confidential and sensitive issues.
- Strong verbal communication, written communication, and organizational skills.
- Ability to handle multiple tasks, projects, and meet deadlines.

Certifications

- Current Paramedic Certification from the State of xxx
- Current Community Paramedic Certification
- Current certification in Advanced Cardiac Life Support and Cardiopulmonary Resuscitation
- Valid State of xx motor vehicle operating license, with continued safe driving history

Physical Demands

Make sure to include this description under physical demands and then delete this line.

Indicate how much time this position spends completing the following physical activities or working in the following environments by double clicking on the boxes.

Physical Activity & Work Environment	Not Applicable	Less than 50%	More than 50%
• Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Using hands/fingers to feel or handle items	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Reaching, pushing or pulling with arms/hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Kneeling, crawling, or crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Talking or hearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Tasting or smelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Lifting, moving or exerting force of up to 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Lifting, moving or exerting force of up to 25 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Lifting, moving or exerting force of up to 50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Lifting, moving or exerting force of up to 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Lifting, moving or exerting force of more than 100 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Seeing up close	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Seeing long distances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Seeing color	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Use of peripheral vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Perceiving depth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Adjusting and focusing vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Working outdoors in inclement weather – extreme hot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Working outdoors in inclement weather – extreme cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Working indoors in an office environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Working in high places	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Working near moving mechanical parts and machines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Working in wet/humid conditions that are not weather related	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Working in extreme cold conditions that are not weather related	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Working in extreme hot conditions that are not weather related	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Working with airborne particles or fumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Working with toxic or caustic chemicals or agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Working with explosives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Working in an area with a risk of exposure to radiation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Working in an area with a risk of exposure to electrocution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Exposure to vibration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Working in a loud environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PROFESSIONAL SERVICES AGREEMENT

THIS AGREEMENT is made and entered into the day and year set forth below, by and between _____ (“_____”), whose mailing address is _____, hereinafter referred to as the “Principal,” and _____, a _____ corporation (“_____” or “Contractor”) and (collectively, the “Parties”)

WHEREAS _____ is the owner and operator of a Medical Practice Clinics in _____ (the “Clinic”); and

WHEREAS _____ employs _____ in the Clinic who is licensed to practice medicine in the State of _____ and is a resident of _____; and

WHEREAS _____ desires to have _____ provide the services from Dr. _____ as the Medical Director of _____ Community Paramedic Program agrees to provide services related to the Scope of Services attached hereto as Exhibit A, and incorporated herein.

WITNESSETH:

In consideration of the mutual covenants and obligations herein expressed, it is agreed by and between the parties hereto as follows:

1. **Scope of Services.** The Contractor agrees to provide services related to the Scope of Services attached hereto as Exhibit A, and incorporated herein.
2. **Effective Date and Term.** This Agreement shall become effective between the signatories on _____ at 0:00 hours following execution by the Parties. The term of this Agreement shall be through the end of the year in which it is entered, and this Agreement shall be automatically renewed for additional one (1) year terms, for a maximum of five (5) renewals, unless terminated by written notice, such notice given not less than thirty (30) days prior to the end of the year, unless otherwise agreed by the Parties. The Contractor shall be paid for services rendered prior to the date of termination, subject only to the satisfactory performance of the Contractor’s obligations under this Agreement.
3. **Compensation.** In consideration of the services to be performed pursuant to this Agreement, the Principal agrees to pay Parties a maximum of _____ Dollars per year (\$_____) billed at monthly rate of \$_____. The Contractor shall pay all out-of-pocket expenses incurred while performing the services specified in this Agreement. The Principal shall provide no benefits to the Contractor in addition to the compensation stated above. **The Contractor is obligated to pay federal and state income tax on any moneys earned pursuant to this Agreement. The Contractor is not entitled to workers’ compensation benefits for the performance of the services specified in this Agreement.**

4. Insurance Requirements. During the term of this Agreement, the Contractor shall maintain the following insurance:

(a) Comprehensive General / Professional Liability Insurance for not less than \$150,000 per person and \$600,000 per occurrence.

(b) Automotive Liability insurance in those instances where the Contractor uses an automobile, regardless of ownership, for the performance of services. Insurance will conform to the requirements of the State of Colorado with limits of not less than \$100,000 (bodily injury per person), \$300,000 (each accident) and \$50,000 (property damage).

5. Maintenance of Licenses and Certifications. During the term of this Agreement, the Contractor shall maintain a license to practice medicine in the State of _____, Board Certified in Family Practice and a valid Driver's License.

6. Notice. All notices provided under this Agreement shall be effective when mailed, postage prepaid and sent to the following addresses:

Contractor:

Principal:

with a copy to:

7. Principal Representative. The Principal will designate, prior to commencement of work, its project representative who shall make, within the scope of his or her authority, all necessary and proper decisions with reference to the Scope of Services. All requests for contract interpretations, change orders, and other clarification or instruction shall be directed to the Principal Representative.

8. Independent Contractor. The services to be performed by Contractor are those of an independent contractor and not of an employee of the Principal.

9. Personal Services. It is understood that the Principal enters into this Agreement based on the special abilities of the Contractor and that this Agreement shall be considered as an agreement for personal services. Accordingly, the Contractor shall neither assign any responsibilities nor delegate any duties arising under this Agreement without the prior written consent of the Principal.

10. Acceptance Not Waiver. The Principal's approval or acceptance of, or payment for, any of the services shall not be construed to operate as a waiver of any rights or benefits provided to the Principal under this Agreement.

11. Default. Each and every term and condition hereof shall be deemed to be a material element of this Agreement. In the event either party should fail or refuse to perform according to the terms of this agreement, such party may be declared in default.

12. Remedies. In the event a party declares a default by the other party, such defaulting party shall be allowed a period of ten (10) days within which to cure said default. In the event the default remains uncorrected, the party declaring default may elect to

- (a) terminate the Agreement and seek damages;
- (b) treat the Agreement as continuing and require specific performance; or
- (c) avail himself of any other remedy at law or equity. If the non-defaulting party commences legal or equitable actions against the defaulting party, the defaulting party shall be liable to the non-defaulting party for the non-defaulting party's reasonable attorney fees and costs incurred because of the default.

13. Indemnification. Contractor agrees to indemnify and hold harmless Principal from any and all damages and liabilities arising from Contractor's performance of the Scope of Services.

14. Binding Effect. This writing constitutes the entire agreement between the parties and shall be binding upon said parties, their officers, employees, agents and assigns and shall inure to the benefit of the respective survivors, heirs, personal representatives, successors and assigns of said parties.

15. Law/Severability. The laws of the State of _____ shall govern the construction, interpretation, execution and enforcement of this Agreement. In the event any provision of this Agreement shall be held invalid or unenforceable by any court of competent jurisdiction, such holding shall not invalidate or render unenforceable any other provision of this Agreement.

*****SIGNATURE PAGE FOLLOWS*****

CONTRACTOR:

By: _____

Date: _____

PRINCIPAL:

By: _____

Date: _____

EXHIBIT A
SCOPE OF SERVICES

The following services will be performed within the scope of the Community Paramedic Program.

1. Provide clinical supervision of up to 5 Community Paramedics.
2. Provide clinical direction in the development of protocols, policies and procedures.
3. Assist in the ongoing development and implementation of a quality improvement and assurance system.
4. When appropriate, outreach to other physicians to increase the network of medical providers participating in the community paramedic program.
5. Participate on and provide leadership to the Community Paramedic Advisory Committee.
6. Work with Dr. _____ to ensure quality of care and continued oversight.
7. Safeguard protected health information of individuals and the confidentiality of situations for which Physician's consultation is requested, in accordance with the rules of _____ and the Health Information Privacy and Accountability Act.
8. Comply with appropriate standards of customer service to the public and provide appropriate consultation in the development and implementation of Community Paramedic protocols to promote the maintenance of high standards of customer service and professionalism.



The Right Community Paramedic Student

BACKGROUND:

With this new evolving field in Emergency Paramedic Service (EMS), it is the goal to set up students and agencies for success. Since the development of the Community Paramedic Curriculum in 2007, many courses have been conducted at educational institutions around the country. In addition, evaluations have been done during and after several courses that included surveying students, instructors, and administrators. The results have led to recommendations for choosing the “Right Community Paramedic Student”.

CRITERIA RECOMMENDATIONS:

- Ample field/clinical experience
- Expert communicators written and oral
- Knowledge of health care systems
- Multi-professional team work
- Motivated lifelong learners
- Knowledge of health maintenance and promotion
- Spends ample time with patients
- Future longevity with the current organization

SELECTING APPROPRIATE LEARNERS:

- 4 – 5 years of experience as a paramedic or EMT
- Ability to learn on-line for hybrid courses
- Time available to participate in the course and complete course assignments
- Previous college experience
- Recommended prerequisite courses
 - Anatomy and Physiology
 - Pathophysiology
 - English
 - Math
 - Pharmacology

Community Paramedic TAC Tool Kit The Paramedic Foundation
Pro Forma Budget

<u>Category</u>	<u>2016</u>	<u>2017</u>		
Income	\$ -	\$ -		
	\$ -	\$ -		
Total Income	<u>\$ -</u>	<u>\$ -</u>		
Payroll Expense	Administration	Administration	Total	
Salaries	\$ -	\$ -	\$ -	
FICA	\$ -	\$ -	\$ -	
Medicare Tax	\$ -	\$ -	\$ -	
State Unemployment	\$ -	\$ -	\$ -	
Workers Comp	\$ -	\$ -	\$ -	
Retirement	\$ -	\$ -	\$ -	
Health Insurance	\$ -	\$ -	\$ -	
Contract CP Evaluator	\$ -	\$ -	\$ -	
Overtime	\$ -	\$ -	\$ -	
Total Payroll Expense	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	\$ -
Operations Expense				
Accounting Fees	\$ -	\$ -	\$ -	
Bank Charges	\$ -	\$ -	\$ -	
Board Reimbursement	\$ -	\$ -	\$ -	
Building Repairs	\$ -	\$ -	\$ -	
Communications Equipment	\$ -	\$ -	\$ -	
Computer Equipment	\$ -	\$ -	\$ -	
Dues & Subscriptions	\$ -	\$ -	\$ -	
Election Costs	\$ -	\$ -	\$ -	
Emergency Reserve (3%)	\$ -	\$ -	\$ -	
Gas and Oil	\$ -	\$ -	\$ -	
Insurance	\$ -	\$ -	\$ -	
Lease Interest	\$ -	\$ -	\$ -	
Lease Principal	\$ -	\$ -	\$ -	
Legal Fees	\$ -	\$ -	\$ -	
Maintenance Contracts	\$ -	\$ -	\$ -	
Medical Direction Fee	\$ -	\$ -	\$ -	
Medical Equipment & Supplies	\$ -	\$ -	\$ -	
Misc Expenses	\$ -	\$ -	\$ -	
Office Supplies & Postage	\$ -	\$ -	\$ -	
Public Relations	\$ -	\$ -	\$ -	
Telephone	\$ -	\$ -	\$ -	
Training (Initial)	\$ -	\$ -	\$ -	
Training (Continuing)	\$ -	\$ -	\$ -	
Transport Expense	\$ -	\$ -	\$ -	
Travel	\$ -	\$ -	\$ -	
Website Design	\$ -	\$ -	\$ -	
Utilities	\$ -	\$ -	\$ -	
Vehicle Repair & Maintenance	\$ -	\$ -	\$ -	
Total Operating Expenses	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	
	\$ -			
Capital Expense				
Capital Purchases (Ambulance Ops)	\$ -	\$ -	\$ -	
Capital Purchases (QRT & Education)	\$ -	\$ -	\$ -	
Construction Fund	\$ -	\$ -	\$ -	
Total Capital Expenses	<u>\$ -</u>	<u>\$ -</u>	<u>\$ -</u>	
Total Revenue			\$ -	
Total Expense			\$ -	
Net			\$ -	

0

Title	Hourly Starting	Hourly Midpoint	Hourly Maximum	Annual Midpoint	Retirement	Health Ins	FICA	Medicare	Unemploy.	Total
Program Manager (Contract or .5 FTE)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total Administration				\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Community Paramedic	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Community Paramedic	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Community Paramedic	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Community Paramedic	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Community Paramedic	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Paramedic	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
EMT-Intermediate	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
EMT-Intermediate	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
EMT-Basic /IV	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
EMT-Basic /IV	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Care Van Driver	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Care Van Driver	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Care Van Driver	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Care Van Driver	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Part Time EMT (Any Level)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Part Time EMT (Any Level)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Part Time EMT (Any Level)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Part Time EMT (Any Level)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Part Time EMT (Any Level)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
On-Call Pay	\$ -			\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total Operations				\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
QRT Manager	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
EMS Educator (Shared)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total QRT Program				\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Totals				\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

APPENDIX 7

ENGAGE THE COMMUNITY & STAKEHOLDERS

7.1 – SAMPLE COMMUNITY MEETING AGENDA

7.2 – SAMPLE STAKEHOLDER ENGAGEMENT FORUM AGENDA

7.3 – LIST OF PEOPLE TO ENGAGE

7.4 – SAMPLE TALKING POINTS



Statewide Community Paramedic Stakeholder Meeting Proposal: *Arkansas*

Date: November XXXX

PRESENTATION INFORMATION:

Presenters: Anne Montera and Christopher Montera

Title: Community Paramedic Stakeholder Meeting

Description: The Community Paramedic model, based on international best practices, is a potential solution that provides access to essential healthcare services. In rural areas, like Eagle County, Colorado, the problem is exacerbated due to a higher uninsured rate and shortage of healthcare providers as compared to urban settings. This model is a proven solution in both rural and urban settings. The collaboration between Public Health, primary care and EMS has been instrumental to the early success of the program in Eagle County primarily due to the community stakeholder engagement.

Session Objectives:

1. Explain the national and international history of Community Paramedicine and Mobile Integrated Healthcare Programs
2. Explain how to integrate public and private partnerships to achieve positive health outcomes for the community's at-risk population.
3. Discuss how to mobilize community partnerships and prioritize program objectives and using Public Health best practices
4. Describe how to create an education program, evaluation process, and implement a quality program
5. Participate in stakeholder panel discussions to start planning for the local/state program implementation

Additional Needs: Speakers, Internet, Projector, Wireless Mics

Additional Handouts and Talking Points can be provided and some are attached to this proposal



RECOMMENDED STAKEHOLDER MEETING ATTENDEE LIST:

State/Regional EMS:

- State EMS Director
- State EMS Medical Director
- State EMS Regulations Coordinator

Local EMS Services:

Ask every local agency in the state to send a representative

Payers / Health Plans:

- State Medicare
- State Medicaid
- All major private insurance companies
- State EMS Association
- State Nurses Association (RN, APN)
- State Medical Association (MD, DO, PA)
- State Hospital Association

Government:

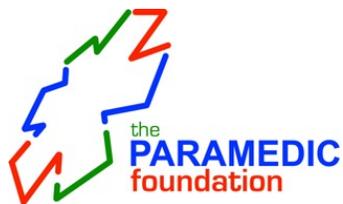
- State Public Health
- Local Public Health
- State VA
- State Rural Health Office
- State Licensing Board
- State Board of Nursing
- Town Managers

Hospitals/Home Health Agencies:

- Hospitals
- Home Health Agencies
- Hospice Agencies
- Long-term Care Facilities
- Primary Care Practices

Colleges/Universities:

- State University
- Community Colleges (Regional CC Systems)
- Medical Schools



PRESENTER INFORMATION:

#1: Anne Montera, RN, BSN
Public Health Nurse Consultant, Caring Anne Consulting, LLC
Board Member, Paramedic Foundation
PO Box 5973, Eagle, CO 81631
970-471-3501
amontera@paramedicfoundation.org

Bio:

Anne Montera received a BSN from Bethel College in Newton, KS. Graduated as a member of Sigma Theta Tau. She has 15 years of nursing experience in Public Health, Labor and Delivery, Neonatal, Pediatrics, Patient Safety / Quality Assurance, and EMS coordination in urban and rural hospitals, clinic, and community settings.

In Ms. Montera's current role as a Public Health Nurse Consultant she works in grant coordination and implementation for various projects in Colorado and across the nation. She is the Co-Creator and Public Health Partner for the first National Community Paramedic Pilot Program in rural Eagle, CO. Ms. Robinson-Montera works to assist local and state Community Paramedic programs through different stages of program development, including statewide stakeholder engagement to local agency implementation.

Ms. Montera has been a leader in the Community Paramedic Curriculum as the college instructor for the 2nd teaching of the curriculum in Colorado. In addition, she lead a team of educators and experts in developing the 3.0 version of the Community Paramedic Curriculum in 2012. She received the Colorado Nightingale Luminary Award for Innovation work on the Colorado Community Paramedic Program in May 2011.

Conferences/Presentations:

- EMS Today 2015
- EMS World Expo 2014, 2015, 2016
- Integrated Healthcare Delivery Forum, 2014
- Philips Presentation, 2014
- BoundTree Presentation, 2013, 2014
- NAEMSE, 2013
- ZOLL Summit, 2013, 2014, 2015
- NOSORH Region E Conference, 2014
- Hawaii EMS Annual Conference, 2013
- The Michigan EMS Summit, 2013
- The Colorado Rural Health Center Annual Conference, Colorado, 2010, 2011



- The International Roundtable of Community Paramedics, Colorado, Canada, United Kingdom and Nevada, 2010, 2012, 2013, 2014, 2015
- Community Paramedic State Stakeholders Meetings; Maine, California, Nevada, 2011; Colorado, North Carolina, South Carolina, Idaho, Pennsylvania, Michigan, North Dakota 2012; Michigan, Colorado, Georgia, Winnipeg, MB, 2013; Wisconsin, Missouri, Wyoming, Indiana, 2014; Arkansas, Colorado 2015.
- Hawaii Medicare Rural Hospital Flexibility Program Conference, Hawaii, 2012
- National Consensus Conference on Community Paramedicine, Georgia, 2012
- National Rural Health Association Annual Conference, Colorado, 2012
- Pinnacle, National Annual EMS Leadership Conference, Colorado, 2012
- North Central EMS Regional Advisory Council Leadership Conference, Colorado, 2012
- North Dakota State Rural Health and Public Health Conference, North Dakota, 2011
- JC REC National Learning Session, Colorado, 2011
- Rocky Mountain Rural Philanthropy Days, Colorado, 2011
- American Ambulance Association Annual Conference, Nevada, 2010
- NASEMSO Annual Meeting, Washington DC, 2010

#2: Chris Montera, AAS, NR-P
Assistant CEO, Eagle County Paramedic Services
PO Box 990, Edwards, CO 81632
970-328-1130
cmontera@ecparamedics.com

Bio:

Chris is the Assistant CEO and Chief of Clinical Services at Eagle County Paramedic Services in Eagle, CO. Chris is the immediate past president of the Emergency Medical Services Association of Colorado and was the EMS Data Specialist for Western Regional Emergency Trauma Advisory Council under contract to serve the State of Colorado. Chris has 23 years of experience in EMS and has received numerous awards for service. In his career he has worked in the Fire Service, Public Health and several EMS services. JEMS and PhysioControl named him one of the Top 10 EMS Innovators of the Year in 2010 for his work in Community Paramedicine. In his spare time he enjoys being a geek, producing his internet radio show EMS Garage (<http://www.emsgarage.com>), and other Colorado outdoor activities.

Conferences/Presentations:

- EMS Today 2014, 2015
- Philips Presentation, 2014
- BoundTree Presentation, 2013, 2014
- EMS World Expo, 2013
- ZOLL Summit, 2013, 2014



- Hawaii EMS Annual Conference, 2013
- The Michigan EMS Summit, 2013
- The Colorado Rural Health Center Annual Conference, Colorado, 2010, 2011
- The International Roundtable of Community Paramedics, Colorado, Canada, and Nevada, 2010, 2012, 2014
- Community Paramedic State Stakeholders Meetings; California, Nevada, 2011; Colorado, North Carolina, South Carolina, Idaho, Pennsylvania, Michigan, 2012; Winnipeg, MB, 2013; Wisconsin, Wyoming, Florida, Indiana, 2014; Colorado 2015.
- National Consensus Conference on Community Paramedicine, Georgia, 2012
- National Rural Health Association Annual Conference, Colorado, 2012
- Pinnacle, National Annual EMS Leadership Conference, Colorado, 2012
- North Central EMS Regional Advisory Council Leadership Conference, Colorado, 2012
- North Dakota State Rural Health and Public Health Conference, North Dakota, 2011
- JC REC National Learning Session, Colorado, 2011
- Rocky Mountain Rural Philanthropy Days, Colorado, 2011
- American Ambulance Association Annual Conference, Nevada, 2010
- NASEMSO Annual Meeting, Washington DC, 2010

PRESENTER AND TRAVEL COSTS:

Honorariums: \$1,000 each, \$2,000 total for a one-day session

Travel Costs:

- Flights to be reimbursed prior to speaking event
- \$500 travel time
- \$620 each for airfare
- \$100 car rental plus fuel costs
- \$109 hotel room, 2 nights plus taxes

Per Diem: \$75.00/day/per person

TOTAL COSTS: \$4,508 plus additional travel cost TBD.



Dear,

On behalf of the International Roundtable on Community Paramedicine it is my honor to invite you to our California stakeholder meeting to be held in San Francisco on August 26, 2011 from 1-4 pm. The meeting will be held at the main headquarters of the San Francisco Fire Department located at 698 Second Street. This will be the opportunity for stakeholders in California's healthcare system to be introduced to the community paramedic model and learn how this new concept in augmenting existing healthcare and social service systems can dramatically improve patient health and well being while reducing healthcare costs.

Research shows that high-risk and high-need populations rely on EMS and hospital ED's as their primary access to all care. This reliance on emergency services has been a driving force in the ever-increasing healthcare costs across the nation. Although modern EMS developed in the late 1960s as a solely reactionary force primarily focused on responding to life threatening emergencies, the Department of Transportation's *EMS Agenda for the Future*, published in 1996, envisioned these systems evolving to become proactive services that act as an integrated part of the overall healthcare system. The IRCP has been working to create a codified curriculum to educate experienced paramedics to fulfill this role. Pilot projects employing the community paramedic approach to improving healthcare and reducing costs have been created in Colorado, North Carolina, Minnesota, Texas and across Canada. The IRCP is using those experiences to improve its curriculum, which is being offered free of charge to universities around the world.

Community paramedics are educated to engage clients into other helping systems and bridge the gap between emergency care and the type of long-term care engendered by other aspects of the healthcare and social service systems. Thus community paramedics will not replace or supplant the efforts of other practitioners, but actually improve their ability to reach underserved populations. Every community paramedic pilot project has been shown to improve healthcare and reduce health costs.

The California stakeholder meeting will focus on creating an education program through the University of California and pilot projects that can be studied for effectiveness. We look forward to your participation at this meeting and assistance in advancing the effort to establish community paramedics as a vital part of California's EMS systems and its overall approach to healthcare. **Please RSVP to niels.tangherlini@gmail.com or call me at (510) 225-8365.** Thank you for your time.

Sincerely,
Niels Tangherlini NREMT-P BA



Stakeholder's Meeting Attendee List

State/Regional EMS:

- State EMS Chief
- State EMS Medical Director
- State EMS Regulations Coordinator

Local EMS Services:

Ask every local agency in the state to send a representative

Payers / Health Plans:

- State Medicare
- State Medicaid
- All major private insurance companies
- State EMS Association
- State Nurses Association (RN, APN)
- State Medical Association (MD, DO, PA)
- State Hospital Association

Government:

- State Public Health
- Local Public Health
- State VA
- State Rural Health Office
- State Licensing Board
- State Board of Nursing
- Town Managers

Hospitals/Home Health Agencies:

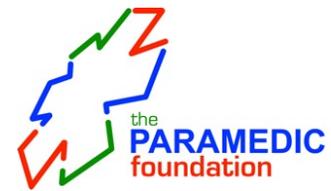
- Hospitals
- Home Health Agencies
- Hospice Agencies
- Long-term Care Facilities
- Primary Care Practices

Colleges/Universities:

- State University
- Community Colleges (Regional CC Systems)
- Medical Schools

Speakers:

- 2 Speakers from the NCEMSI
- Key Note Speaker
- State CP Representative



Opportunity Statement

- **Severe Primary Care Shortage** currently exists and is on the rise
- **Vulnerable populations with new health insurance plans will not have access to a provider** because of the increase in demand
- **Cost of healthcare continues to rise** with Emergency Rooms being the most available alternative
- **Access to care problems are exacerbated in rural areas** due to higher healthcare provider shortages, a larger elderly population than urban, and transportation barriers

Community Paramedic Solution

The Community Paramedic (CP) model is an innovative, proven solution to provide high quality primary care and preventative services by employing a currently available and often underutilized healthcare resource.

How Does it Work?

A primary care partner refers a patient to Emergency Medical Services (EMS) personnel to provide services in the home that are within their current scope of practice including: hospital discharge follow-up, fall prevention in the home, blood draws, medication reconciliation or wound care. The CP provides care and communicates health records back to the referring physician to ensure quality of care and appropriate oversight. In addition works with Public Health to provide preventative services throughout the community.

The goals of Eagle County's Community Paramedicine program are twofold: 1) To improve health outcomes among medically vulnerable populations, and 2) save healthcare dollars by preventing unnecessary ambulance transports, emergency department visits, and hospital readmissions.

Advantages

- Decreases workload and increases quality and efficiency of managing patients in a primary care and public health settings by utilizing EMS Personnel through non-traditional methods
- EMS personnel are integrated throughout the healthcare system, improving access and decreasing healthcare cost
- CP certification provides a job opportunity where EMS volunteer work is often the only sustainable model in rural areas
- EMS personnel currently have the training, expertise and scope of practice to provide essential primary care services
- The program has a proven track record locally and internationally

Frequently Asked Questions

Q: Does a CP replace current healthcare systems like home health care or primary care physicians?

A: No. CP is an extension of the primary care provider to provide care to patients without access, and does not replace the specialized services available in a home health care model or physician office.

Q: Does a CP have the right training to provide primary care?

A: Additional education is provided to CP specific to providing preventive care in the home within their current scope. However, services provided do not fall out of the currently defined scope of practice for EMS personnel.

Q: Is the quality of care compromised by using a CP vs. a primary care provider?

A: No. A CP provides care under the supervision of a physician, so the quality of care is consistent with care provided in a clinic setting.

Questions?

Christopher Montera: cmontera@ecparamedics.com; Anne Montera: amontera@paramedicfoundation.org;

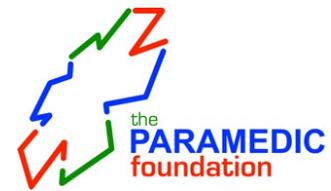
Gary Wingrove: wingrove@paramedicfoundation.org



EAGLE COUNTY
PARAMEDIC SERVICES



COMMUNITY
PARAMEDIC



Programmatic Statistics Eagle County Health Service District (AKA: Eagle County Paramedic Services)

Patient Profile July 2012 – December 2013:

- 55 were patients served, 216 visits were provided
- Each patient was seen between 1 and 5 times (3 patients were outliers)
- The median client age was 60; 36% patients were under age 10; 47% were 65+ years old
- Gender, 40% male and 60% female

Diagnosis (Patients may have more than one diagnosis):

- 57% cardiac, 18% psychiatric issues, 17% diabetes, 12% respiratory issues

Co-Morbidities and Risk Factors:

All patients were considered medically vulnerable due to co-morbidities and risk factors:

- 57% had Cardiac issues (Coronary artery disease, congestive heart failure, history of heart problems, myocardial infarction, hypertension, edema)
- 18 % had a Mental Health issue, in addition to other medical needs
- 21.8% of the patients had been hospitalized in the last 6 months of those 47 visits, 53.2% were related to the patient's recent hospitalization

Services Ordered:

- In 60% of visits, medication compliance and reconciliation was ordered
- In 26% of visits Ability to Ambulate (Fall screening) was ordered
- In 26% of visits, a blood pressure check was ordered
- In 15% of visits, a blood glucose test was ordered
- In 16% of visits, diabetic education or follow-up was ordered
- In 18% of visits, a home safety inspection was ordered
- In 10% of visits, a social and/or adult protection evaluation/assessment of alcohol usage ordered

Higher Level of Service Utilization Prevented:

- Prevented 120 doctor visits, 28 ambulance transports, 26 emergency room visits, 3 hospital admissions/readmissions, and kept one client out of skilled nursing for 562 days.

Initial Cost Savings:

- \$1,333 average savings per visit
- \$5,237 average savings per client/patient
- \$288,028 (net) total healthcare costs SAVED in 18 months

Health Care Statistics

Primary care shortage:

- In July 2011, 52 of CO's 64 counties (81%) were either fully or partially designated as a Health Professional Shortage Area

Uninsured/Underinsured rates:

- In 2010, 14.7% (342,122) of CO residents reportedly did not see a doctor in the previous 12 months, due to costs.
- During 2012, 15.5% of Eagle County residents were reportedly uninsured, compared to CO at 14.4%

Access to care statistics:

- Colorado's overall population is projected to grow by 20% between 2010 and 2020, while the population ages 65+ is projected to grow at nearly twice that rate (37%) during the same time period.
- In 2005, 38% of Eagle County households reportedly had trouble accessing health care
- In 2005, 43% of Eagle County residents reportedly were unable to access dental care

Questions?

Christopher Montera: cmontera@ecparamedics.com; Anne Montera: amontera@paramedicfoundation.org;

Gary Wingrove: wingrove@paramedicfoundation.org

APPENDIX 8

DEVELOP POLICES & PROCEDURES

8.1 – REFERRAL FORM

8.2 – CP CONSENT FORM

8.3 – HOME SAFETY ASSESSMENT

8.4 – PHQ2

8.5 – PHQ9

8.6 – DISCHARGE SUMMARY

8.7 – ECPS POLICY AND PROCEDURE

8.8 – ECPS COMMUNITY PARAMEDIC PROTOCOLS WINTER 2018

8.9 – COMMUNITY PARAMEDIC CQI FORM



Community Paramedic Patient Order Form

PATIENT INFORMATION <small>(May submit patient face sheet for demographics)</small>					PLEASE RETURN BY FAX TO 866-623-9948				
Date of Order:		Requested Date of Service:			Primary Language:				
Client Name: Last		First		Middle		DOB:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Physical Street Address			City/Town		State		Zip Code		Phone Number
Mailing Address (if different)			City/Town		State		Zip Code		Secondary Phone
Insurance (For research purposes only): <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, company: _____									
DIAGNOSIS					PREVENTION ASSESSMENTS				
Diagnosis : _____					<input type="checkbox"/> Nutrition Assessment <input type="checkbox"/> Social Evaluation / Social Support <input type="checkbox"/> Home Safety Inspection				
Reason for Visit: _____									
LABORATORY SPECIMEN COLLECTION					PLEASE INCLUDE AGENCY CLINICAL LAB TESTING ORDER SHEET				
<input type="checkbox"/> Blood Draw		<input type="checkbox"/> iStat Test		<input type="checkbox"/> Stool Collection		<input type="checkbox"/> Urine Collection			
Requested Labs/Blood Tubes: _____									
CLINICAL CARE									
<u>Cardiovascular</u>			<u>Respiratory</u>			<u>General</u>			
<input type="checkbox"/> Blood Pressure Check			<input type="checkbox"/> Asthma Meds/Education/Compliance			<input type="checkbox"/> Assessment / H&P			
<input type="checkbox"/> EKG 12 Lead			<input type="checkbox"/> CPAP			<input type="checkbox"/> Ear exams			
<input type="checkbox"/> Peripheral Intravenous Lines			<input type="checkbox"/> MDI Use			<input type="checkbox"/> Medication Evaluation or Medication Compliance			
<u>Follow-up/Post Discharge</u>			<input type="checkbox"/> Nebulizer Usage/Compliance			<input type="checkbox"/> Post Injury/Illness Evaluation			
<input type="checkbox"/> Diabetic Follow-up/Education			<input type="checkbox"/> Peak Flow Meter Education/Usage			<input type="checkbox"/> Ambulatory detox			
<input type="checkbox"/> Neurological Assessment			<input type="checkbox"/> Oxygen Saturation Check			<input type="checkbox"/> Weight Check			
<input type="checkbox"/> Dressing Change/Wound Check/Type: _____									
<input type="checkbox"/> Discharge Follow-up/Diagnosis: _____									
Other Orders/Information: _____ _____									
PUBLIC HEALTH/SOCIAL SERVICES/ADULT PROTECTION									
<input type="checkbox"/> Bright Beginnings		<input type="checkbox"/> EHS Post Partum Visit		<input type="checkbox"/> Fluoride Varnish Clinic		<input type="checkbox"/> Welfare Check/Medical Assessment			
<input type="checkbox"/> Disease Investigation		<input type="checkbox"/> IZ Clinic Coverage		<input type="checkbox"/> TB Meds DOT					
ORDERING PHYSICIAN SIGNATURE (MUST BE SIGNED)					Disclaimer: All visits will be accomplished as soon as possible but generally within 24 – 72. All services provided must be within the scope of practice of a paramedic as described in 6 CCR 1015-3 Chapter 2, EMS Practice and Medical Director Oversight Rules. Paramedics will verify that orders fall within this scope of practice and will contact you if orders need clarification or further instruction.				
Contact Number: _____									
Referring Physician: _____ <small>(Please Print)</small>									
_____ Signature			_____ Date						
<input type="checkbox"/> Fax report back to referring physician <input type="checkbox"/> Fax report to: _____									



Consent/Authorization to Release Health Information

PATIENT INFORMATION		PLEASE RETURN BY FAX TO 866-623-9948	
Patient's Last Name	First	Middle	DOB
INFORMATION			
<input type="checkbox"/> Consult	<input type="checkbox"/> Labs	<input type="checkbox"/> Immunization Record	
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Physician Progress Notes	<input type="checkbox"/> Other as specified below:	
<input type="checkbox"/> Emergency Department Report	<input type="checkbox"/> MRI Report	_____	
<input type="checkbox"/> EKG Tracings	<input type="checkbox"/> Operative Report	_____	
<input type="checkbox"/> Graphic Record	<input type="checkbox"/> X-Ray Report	_____	
<input type="checkbox"/> History and Physical	<input type="checkbox"/> X-Ray MRI	_____	
Date of Order:	Purpose of Release:		
This consent/authorization is to release health information from and to:			
Name		Phone Number	
Address	City	State	Zip Code
This consent/authorization will remain in effect			
<input type="checkbox"/> From the date it is signed out until: _____ <input type="checkbox"/> Until the following event occurs: _____			
Note: IF neither of the above options is selected, this consent/authorization will remain in effect for 180 days from the date this it is signed.			
I authorize my health information described above to be released to Eagle County Paramedic Services' Community Paramedic Program to send all copies of my health record back to the above named entity for the purpose of continuity of care and understand that:			
<ol style="list-style-type: none"> 1. Information disclosed pursuant to this Consent/Authorization may include information relating to sexually transmitted disease, AIDS/HIV, and physiological or psychiatric conditions, unless restricted as follows: 2. Once information is disclosed pursuant to this signed Consent/Authorization, I understand that the federal privacy law (45 C.F.R parts 160 and 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from disclosing it. 3. I may revoke this Consent/Authorization at any time, except to the extent that action has been taken in reliance on it. To revoke it, I must provide the Privacy Officer-at the address listed at the top left of this form-with a written revocation which will not be effective until received and approved by the Privacy Officer. 4. I may refuse to sign this Consent/Authorization and this refusal will not affect the Treatment Eagle County Paramedic Services' Community Paramedic Program provides to the patient, unless the patient is seeking health care services solely for the purpose of creating health information for disclosure to a third party. 			
Signature of Patient/Parent of Legal Representative		Date	
If signed by Legal Representative, Legal Representative's authority to act on behalf of patient: Relationship to patient:			
For Office Use ONLY			
Date Information Released		Medical Record Number	
Information Release by:			

Date of visit: _____

Occupant name: _____ Paramedic Name: _____

OUTSIDE OF HOUSE

1. Sidewalk and/or pathway to house is level and free from any hazards. Yes ___ No ___ N/A ___
2. Driveway is free from debris/snow/ice. Yes ___ No ___ N/A ___
3. Outside stairs are stable and have sturdy handrail. Yes ___ No ___ N/A ___
4. Porch lights are working and provide adequate lighting. Yes ___ No ___ N/A ___

LIVING ROOM

1. Furniture is of adequate height and offers arm rests that assist in getting up and down. Yes ___ No ___ N/A ___
2. Floor is free from any clutter that would create tripping hazards. Yes ___ No ___ N/A ___
3. All cords are either behind furniture or secured in a manner that does not cause trip hazards. Yes ___ No ___ N/A ___
4. All rugs are secured to floor with double-sided tape. Yes ___ No ___ N/A ___
5. Lighting is adequate to light room. Yes ___ No ___ N/A ___
6. All lighting has an easily accessible on/off switch. Yes ___ No ___ N/A ___
7. Phone is readily accessible near favorite seating areas. Yes ___ No ___ N/A ___
8. Emergency numbers are printed near all phones in house. Yes ___ No ___ N/A ___

KITCHEN

1. Items used most often are within easy reach on low shelves. Yes ___ No ___ N/A ___
2. Step stool is present, is sturdy and has handrail. Yes ___ No ___ N/A ___
3. Floor mats are non-slip tread and secured to floor. Yes ___ No ___ N/A ___
4. Oven controls are within easy reach. Yes ___ No ___ N/A ___
5. Kitchen lighting is adequate and easy to reach switches. Yes ___ No ___ N/A ___
6. ABC fire extinguisher is located in kitchen. Yes ___ No ___ N/A ___

STAIRS

1. Carpet is properly secured to stairs and/or all wood is properly secured. Yes ___ No ___ N/A ___
2. Handrail is present and sturdy. Yes ___ No ___ N/A ___
3. Stairs are free from any clutter. Yes ___ No ___ N/A ___
4. Stairway is adequately lit. Yes ___ No ___ N/A ___

BATHROOM

1. Tub and shower have a non-slip surface. Yes ___ No ___ N/A ___
2. Tub and/or shower have a grab bar for stability. Yes ___ No ___ N/A ___
3. Toilet has a raised seat. Yes ___ No ___ N/A ___
4. Grab bar is attached near toilet for assistance. Yes ___ No ___ N/A ___
5. Pathway from bedroom to bathroom is free from clutter and well lit for ease of movement in the middle of the night. Yes ___ No ___ N/A ___

BEDROOM

1. Floor is free from clutter. Yes ___ No ___ N/A ___
2. Light is near bed and is easy to turn on. Yes ___ No ___ N/A ___
3. Phone is next to bed and within easy reach. Yes ___ No ___ N/A ___
4. Flashlight is near bed in case of emergency. Yes ___ No ___ N/A ___

GENERAL

1. Smoke detectors in all areas of the house (each floor) and tested. Yes ___ No ___ N/A ___
2. CO detectors on each floor of house and tested. Yes ___ No ___ N/A ___
3. Flashlights are handy throughout the home. Yes ___ No ___ N/A ___
4. Resident has all medical information readily available and in an area emergency providers will easily find. Yes ___ No ___ N/A ___
5. All heaters are away from any type of flammable material. Yes ___ No ___ N/A ___
6. Are there any issues or hazards to having oxygen in the home? Yes ___ No ___ N/A ___
7. Are there any issues or hazards to having pets in the home? Yes ___ No ___ N/A ___
8. Oxygen equipment inspected and current. Yes ___ No ___ N/A ___

OVERALL TIPS

1. Homeowner has good non-skid shoes to move around house. Yes ___ No ___ N/A ___
2. All assisted walking devices are readily accessible and in good condition. Yes ___ No ___ N/A ___
3. There is a phone near the floor for ease of reach in case of a fall. Yes ___ No ___ N/A ___
4. All O2 tubing is less than 50 ft. and is not a trip hazard. Yes ___ No ___ N/A ___
5. Resident has had an annual hearing and vision check by a physician. Yes ___ No ___ N/A ___
6. Resident has the proper hearing and visual aides prescribed and are in good working order. Yes ___ No ___ N/A ___
7. All medications are properly stored and labeled to avoid confusion on dosage, time to take, and avoidance of missed doses. Yes ___ No ___ N/A ___

FOR ALL SECTIONS MARKED 'NO' THE FOLLOWING RECOMMENDATIONS ARE NOTED BELOW

After evaluation I recommend the resident be considered for the following referrals.

Signature of resident: _____

Signature of Community Paramedic: _____

References: Centers for Disease Control and Prevention / <http://www.cdc.gov>

A. 'Check for Safety' A Home Fall Prevention Checklist for Older Adults

B. U.S. Fall Prevention Programs for Seniors – Selected Programs Using Home Assessment and Modification.

*Compiled and created by Kevin Creek NREMT-P / Community Paramedic
Western Eagle County Health Services District, 360 Eby Creek Road, P.O. Box 1809, Eagle CO 81631
May 2011*



Patient Health Questionnaire-2: Screening Instrument for Depression

OVER THE PAST TWO WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	NOT AT ALL	SEVERAL DAYS	MORE THAN ONE-HALF THE DAYS	NEARLY EVERY DAY
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

NOTE: *If the patient has a positive response to either question, consider administering the Patient Health Questionnaire-9 or asking the patient more questions about possible depression. For older adults, consider the Patient Health Questionnaire-9 or the 15-item Geriatric Depression Scale. A negative response to both questions is considered a negative result for depression.*
 Adapted from patient health questionnaire (PHQ) screeners. <http://www.phqscreeners.com>. Accessed September 6, 2011.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + + +
=Total Score:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult



Discharge Summary Form

Patient name: _____

Date of birth: _____

Date of discharge: _____

Paramedic: _____

Services provided: (check all provided during course of patient care)

- Medication evaluation/compliance Nutrition assessment Social evaluation/support Home safety inspection
- Phlebotomy INR check Blood pressure check EKG / 12 Lead EKG Stool/urine collection Diabetic follow-up/education
- Neurological assessment Dressing change / wound check Discharge follow-up Respiratory evaluation / follow-u
- Oxygen saturation check Assessment / H&P Ear exam Post injury/illness follow-up Post stroke follow-up Weight check
- Ambulatory detox program Newborn home visit Crisis Intervention

Other:

Post Community Paramedic care instructions: (needs, goals, follow-up care, diet, medications, post care, signs and symptoms to look for etc...)

For any non-emergent questions regarding your care, please contact the Community Paramedic Supervisor at 970-569-6223.

For any urgent concerns please contact your physician or 911 immediately as this number is not for emergencies.

Paramedic signature: _____

Date: _____

Patient signature: _____

Date: _____

Definitions and Agency Names	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to outline definitions used throughout this document.

Definitions:

1. Eagle County Paramedic Services, henceforth known as ECPS, is the agency who oversees the Community Paramedic program set forth in this document.
2. Community Paramedic, henceforth referred to as CP, is a provider who has acquired the training and certifications set forth in the training section.
3. Community Paramedic medical director, henceforth known as CP MD, is the physician who has been employed by ECPS to provide direct medical oversight of the CP program.
4. Colorado Department of Public Health and Environment, henceforth known as CDPHE, is the governing body for emergency services in the State of Colorado.

Rights of the Consumer	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to insure that all patients served by the CP Program are fully aware of their rights as a consumer and are given written proof thereof.

Policy:

It is the policy of the CP program that each patient seen by the Community Paramedic program receive a copy of the ECPS CP admission packet which contains the following...

1. Right of the consumer to participate in the development of the service plan.
2. The right of the consumer and his or her property to be treated with respect.
3. The right of the consumer to be free from discrimination in the provision of services.
4. The right of the consumer to consent to receive and to discontinue services at any time.
5. The right of the consumer to have personally identifying health information protected from unnecessary disclosure.
6. The right of the consumer or his or her representative to file a complaint with Eagle County Paramedic Services and / or the State of Colorado concerning services or care that is or is not furnished, and receive documentation of the existence of the investigation and resolution of the complaint, including providing the complainant with the results of the investigation and Eagle County Paramedic Services' plan to resolve any identified issues.
7. The right of the consumer to file a complaint with Eagle County Paramedic Services and/or the Department of Colorado without fear of discrimination or retaliation by the CICHS agency owner, administrator or any CIHCS staff.
8. The right of the consumer to formulate an advanced directive.

Procedure:

- Each new patient seen by a CP will receive a copy of the above rights.
- Each new patient seen by a CP will sign the ECPS CP Admission Agreement (to be kept by ECPS).
- Each new patient seen by a CP will sign the Consent / Authorization to Release Health Information (to be kept by ECPS).
- Patients who are seen over a period of time will receive a copy of the above rights and re-sign the Admission Agreement and Consent / Authorization each calendar year.

Rights of the Consumer cont...	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

- A. The admission paperwork given to the patient on the first visit will contain the contact information for the CP program and the ECPS office.
- B. The patient will be made aware that any and all documentation diagnostic and therapeutic procedures, treatments, tests and their results will be made available to them upon request; and
- C. That all releases of personally identifying health information are consistent with applicable state and federal law.

Initial and Continuing Education	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to insure that each CP employed by ECPS receives proper education, obtains certification and maintains that certification.

Policy:

The paramedic will successfully complete a CP course from an accredited institution.

The CP will then successfully complete the International Board of Specialty Certification (IBSC) Community Paramedic Certification (CP-C) exam and obtain the CP-C credential.

The CP will complete on-going continuing education as set forth by the IBSC to maintain the CP-C credential.

The minimum amount of required continuing education shall not be less than twelve (12) hours or twelve (12) sessions per year.

Staffing	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to ensure that the staffing of the CP program meets the requirements of the Colorado Department of Public Health and Environment's standards.

Policy:

1. ECPS does not have a requirement as to how many years an individual has been certified as a paramedic in order to qualify as a CP. Instead, candidates will be assessed individually on their ability to function in the role throughout the interview process, internal testing and overall standing in their current organization.
2. Each CP will adhere to the Employee Conduct section of the ECPS Policies and Procedures manual.
3. CP staffing guidelines will be assessed yearly on the needs of the community and will be adjusted accordingly.
4. Each CP will report directly to the CP Supervisor and will participate in a yearly review which will outline strengths, review areas for improvement and set goals.
5. The CP supervisor will report directly to the clinical manager and follow the same review process.
6. The CP MD will have 100% access to all patient files for the purpose of medical oversight and chart review through the IT system.
7. When the CP Supervisor is unavailable for a period of time, he/she will designate the highest level of seniority CP to assume these duties until they are available again.
8. All Community Paramedics employed by ECPS will submitted for a Colorado Adult Protection Service check which will be kept with the employee's personnel file.
9. ECPS employs two medical directors, a CP MD and a 911 medical director. For the purposes of the CP program, the CP MD is the medical oversight for all patients enrolled in the program.

Training	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to outline the training division of the CP program.

Policy

1. All CP's will complete the new CP hire checklist.
2. All CP's employed by ECPS will receive training on all equipment used by the CP program. This will be administered by the CP Supervisor.
3. The CP will complete on-going continuing education as set forth by the IBSC to maintain the CP-C credential.
4. The CP will receive training and adhere to the Privacy/HIPAA section of the general ECPS Policies and Procedures Manual.
5. The CP will receive training and adhere to the Employee Conduct and problem solution sections of the general ECPS Policies and Procedures Manual.
6. The CP will receive training and adhere to the Eagle County disaster plan as listed in the general ECPS Policies and Procedures Manual.
7. The CP will receive training and adhere to the infection control section of the ECPS Policies and Procedures Manual.
8. The CP will utilize the Total Health Alliance in regards to learning about Community Resources in Eagle County.

Patient eligibility for recurrent services	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to outline which patients are and are not eligible to obtain recurrent services by the CP program.

Policy

1. Patients who qualify for Home Care or Hospice services and are seeking admission with them are not eligible for CP Care.
2. A patient who has been rejected from or declined Home Care or Hospice services is available for admission.
3. The CP will, on first visiting the patient, inquire as to the patients' eligibility for Home Care or Hospice and document this on the Admission Agreement.
4. If it is found that the patient does qualify or is already enrolled with Home Care or Hospice services, the CP will contact the referring physician to inform them we will be unable to admit the patient.
5. Patients who are known to overuse the 911 system are eligible for these services.

Initial assessment requirements	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to outline the procedures for initial assessments for patients enrolled in the CP program at the initial encounter.

Policy

During the initial assessment the CP shall:

1. Assess the patient's physical and psychological status, if applicable, including but not limited to the patient's special needs, communication or language barriers, capabilities, limitations, and short-term and long-term goals.
2. Assess the patient's medical, therapeutic, social, nursing and dietary needs.
3. Obtain a list of the patient's current medications and medication schedule.
4. Identify social support systems, evaluate environment and discuss any transportation accessibility issues and barriers.
5. Assess, obtain and identify other systems, situations, and information as deemed appropriate to improve the patient's life and/or health related outcomes.
6. Any and all pertinent findings shall be added to the patient care report and sent to the referring physician.

Subsequent assessment requirements	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to outline the procedures for subsequent assessments for patients enrolled in the CP program.

Policy

During the initial assessment the CP shall:

1. Assess the patient’s current health status, goals and timeframes for meeting these goals.
2. Document and information that may be used to demonstrate the patient’s progress toward achievement of the desired outcomes.
3. Identify whether the consumer requires continuing services from the CP program or may be discharged.
4. These visits shall occur on the order of the physician or when there is a significant change of condition.
5. Each subsequent assessment shall be submitted to the referring physician for evaluation and use and review.
6. If ordered by a physician to provide subsequent services, the CP supervisor shall review the order and determine if the services ordered are available to be performed by the CP staff and are within their scope of practice.
7. If the CP program determines that the patient lacks adequate resources to obtain or access necessary out –of-hospital medical services, the CP program may provide the patient with such necessary services through a series of visits established in the patient’s service plan that the CP MD shall approve.
8. The CP program will provide the services in accordance with the patient’s service plan within the scope of services of the program, and will ensure continuous oversight of the patient’s care up to and until the patient’s discharge.
9. Evaluation of the patient’s progress based on the goals established in the service plan shall be conducted as set forth in these policies and documented in the patient’s records. The CP program shall then notify the referring physician regarding any changes that suggest a need to alter the patient’s service plan.
10. Each patient service plan shall incorporate a defined discharge summary.

Service Plan	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to outline the specific documentation if the patient's service plan.

Policy

1. The service plan shall include the following:
 - a. The patient's physical and mental status
 - b. The patient's short and long-term health care needs and any goals and timeframes for meeting those goals.
 - c. A description of the out-of-hospital medical services needed to address and satisfy the patient's health-care needs and any non-medical goals.
 - d. The frequency of visits along with the projected number of visits that may be required to address the patient's health care needs and any non-medical goals.
 - e. Identification of and written documentation explaining the CP program's coordination of services provided to the patient, including non-medical related goals outcomes.
 - f. A description of any equipment needed.
 - g. Limitations of the patient's activities.
 - h. A goal for the patient's discharge.
2. For all recurrent services provided the CP program shall ensure the referring physician evaluates the subsequent assessments through the patient care reports submitted by the paramedic and shall re-review the service plan when there is a significant change of condition.

Patient Care Providers	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to identify who will provide care for the patients' enrolled in the CP program.

Policy

1. All paramedics involved in the care of a patient enrolled in the CP program will have obtained the credentials outlined in the 'staffing' section of this document.
2. In the instance where a CP is not available to provide services to a patient who requires a basic task which is in the normal paramedic scope of practice, including but not limited to services such as a blood draw, weight check or blood pressure check, the CP supervisor may ask an Eagle County Paramedic Services line paramedic to perform the task and report back directly to them with their findings.
3. Unless it is vital to continuity of care, patients receiving subsequent visits may be visited by another CP within the program. In cases where it is more appropriate for the same CP to attend the subsequent visit, the CP supervisor shall make every attempt to schedule that individual.
4. In cases where it is more appropriate for either a male or female CP to attend due to a variety of factors, the supervisor shall schedule the appropriate provider.
5. When care for a patient receiving subsequent visits is done by multiple providers, the attending provider shall review the previous documentation to ensure continuity of care.

Documentation	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to outline the documentation requirements for the CP program.

Policy

1. Every patient visit will be documented in the patient care record and stored in the patient file.
2. Each patient care report will be sent to the referring physician within 24 hours of the completion of the visit.
3. If there are circumstances where the CP feels the referring physician needs to be made immediately aware of the patient's condition or other factors found on the visit, the CP will also call the physician's office and request to speak to the nurse or physician prior to sending the report and give a verbal account of their concerns.
4. Along with the patient care report the CP will send any accompanying paperwork related to the visit such as but not limited to; home safety assessment, PHQ-9 or other assessments performed by the CP.

Discharge	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to outline the discharge policy for the CP program.

Policy

1. It is the policy of the ECPS CP program to only visit patients on a referral basis in which the number of visits is clearly defined.
2. For patients receiving multiple visits, when the final visit has taken place, the CP will include in the documentation that the patient will no longer receive services from the ECPS CP program which will be done within 24 hours after the final visit.
3. Each patient will be made aware that the agency may solicit consumer input regarding his or her satisfaction with the CP provider and services received for quality management purposes.
4. The CP will provide a discharge summary form for each patient who has received multiple visits and will be discussed with the patient or designated representative prior to discharge and shall include:
 - a. An evaluation of the post-CP care needs and goals as outlined in the service plan, and a summary of the services the patient received.
 - b. Contact information for the patient to call in case the patient has questions after discharge.
 - c. Written instructions about self-care, follow-up care, modified diet, medications, and signs and symptoms to be reported to the patient's care provider(s).

Complaints	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to outline the complaint process for the patient if it is so merited.

Policy:

1. The patient will be provided with:
 - a. Contact information for ECPS and the staff responsible for complaint intake and problem resolution.
 - b. The process by which they can submit verbal or written complaints to the Colorado Department of Public Health and Environment and/or ECPS about services or care.
 - c. Information on how the agency will document investigation of, and resolution process for, any complaint made concerning ECPS CP services and providers, including ECPS's mandatory notification to the complainant about the results of the investigation and ECPS's plan to resolve the identified issue(s).
 - d. ECPS's incorporation of the substantiated findings of any complaint into its quality management program for the purpose of evaluating and implementing systematic changes where needed.
 - e. ECPS's explicit statement that it does not discriminate or retaliate against a patient for expressing a complaint or multiple complaints.
2. Complaints in writing against medical directors for violations of these rules may initiated by any person, the Colorado Medical Board, the Colorado Board of Nursing or the Colorado Department of Health and Environment (CDPHE).
 - a. The CDPHE may refer complaints made against medical directors to the Colorado Medical Board or the Colorado Board of Nursing.
3. ECPS shall refer to the appropriate regulatory body any credible allegation made against an ECPS CP provider who is licensed, regulated or certified concerning the provision of care to the patient, including an allegation concerning a provider acting outside of his or her scope of practice.

Reporting Occurrences	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to outline the reporting requirements

Policy:

1. The ECPS CP program shall report the following occurrences to the Colorado Department of Health and Environment in the format required by them by the next business day after the occurrence or when the ECPS CP program becomes aware of the occurrence.
2. The following occurrences shall be reported:
 - a. Any occurrence that results in the death of a patient of the CP program and is required to be reported to the coroner as arising from an unexplained cause or under suspicious circumstances.
 - b. Any occurrence that results in any of the following serious injuries to a patient:
 - i. Brain or spinal cord injuries
 - ii. Life-threatening complications of anesthesia or life-threatening transfusion errors or reactions.
 - iii. Second or third degree burns involving twenty percent or more of the body surface area of an adult patient or fifteen percent or more of the body surface area of a child patient.
 - c. Any time that a patient of the CP program cannot be located following a reasonable search of the area, and there are circumstances that place the patient's health, safety or welfare at risk or, regardless of whether such circumstances exist, the patient has been missing for eight hours.
 - d. Any occurrence involving physical, sexual or verbal abuse of a patient by an employee or contractor of the ECPS CP program.
 - e. Any occurrence involving neglect of a patient.
 - f. Any occurrence involving misappropriation of a patient's property. For purposes of this paragraph, "misappropriation of a patient's property" means a pattern of or deliberately misplacing, exploiting or wrongfully suing, either temporarily or permanently, a patient's belongings or money without the patient's consent.
 - g. Any occurrence in which drugs intended for use by the patient are diverted to use by other persons.
 - h. Any occurrence involving the malfunction or intentional or accidental misuse of a patient's care equipment that occurs during treatment or diagnosis of a patient and that significantly adversely affects or if not averted would have significantly affected a patient of the CP program.

3. Any agency reports submitted shall be strictly confidential.
4. The Colorado Department of Public Health and Environment may request further oral or written reports of the occurrence if it determines such a report is necessary.
5. No ECPS owner, administrator or employee thereof shall discharge or in any manner discriminate or retaliate against any patient of the CP program, or any other person because such person, relative, legal representative, sponsor or employee has made in good faith or is about to make in good faith, a report pursuant to this policy or has provided in good faith or is about to provide in good faith evidence in any proceeding or investigation relating to any occurrence required to be made by the CP program.
6. Nothing in this policy shall be construed to limit or modify any statutory or common law right, privilege, confidentiality or immunity.
7. Nothing in this policy shall affect a person's access to his or her medical record, nor shall it affect the right of a family member or any other person to obtain medical record information upon the consent of the patient or his/her authorized representative.

Other Required Reporting	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to outline other required reporting.

Policy:

1. The ECPS CP program shall ensure that:
 - a. All staff have knowledge of Article 3.1, Part 1 of Title 26, C.R.S., regarding protective services for at-risk adults.
 - b. All staff shall have knowledge of Article 3, Part 3 of Title 19, C.R.S., if the CP program provides services to pediatric patients.
 - c. All incidents involving neglect, abuse or financial exploitation are reported immediately, through established procedure, to the ECPS CP CEO and the CP program supervisor.
2. In addition to the CP program's reporting requirements as described in this policy, the CP program shall report all incidents described in this policy of these rules to the appropriate officials as specified in statute. The CP program shall make copies of all such reports available to the Colorado Department of Health and Environment upon request.

Quality Management Program	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to outline the standards for the CP Quality Management program.

Policy:

1. The Quality Management program shall include:
 - A. The ECPS Quality Manager will oversee the CP quality management program.
 - B. All protocols are reviewed and approved by the CP MD.
 - C. 100 % of the charts written will be reviewed by the CP MD and evaluated for appropriate patient care and to evaluate for any potential risks. Each chart review will be documented by the CP MD for quality of patient care, appropriateness, areas for improvement and the measurement of effectiveness for reducing unnecessary 911 calls, ED visits, hospitalizations or other unwanted outcomes.
 - D. The CP MD will report all findings to the CP supervisor and the ECPS Quality Manager for appropriate follow-up.
 - E. The CP MD will review patient care charts monthly and submit them to the ECPS Quality Manager.
 - F. The CP MD will report any immediate concerns to the CP supervisor via email or phone call within 3 days of the immediate concern.
 - G. Any and all problems identified with any aspect of patient care found by the medical director will be brought to the attention of the CP supervisor and administrator in order that it may be investigated and to determine what, if any, corrective actions need to be taken.
 - H. The CP program and CP MD will review the discharge planning process annually.
 - I. The CP program and CP MD will review treatment protocols and the compliance of these protocols annually.
 - J. In addition, the CP program will follow the Quality Management Program guidelines as set forth in the ECPS Policies and Procedures manual, section 8.

Records	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to outline the standards for record keeping for the CP program.

Policy:

1. Each patient contact shall be documented in the PCR system and stored in the patient file.
2. Each phone contact made with the patient, nurse, physician or anyone else involved in the care of the patient shall be documented in the 'chronological' form stored in the patient file.
3. Each patient care record shall be retained for no less than 4 (four) years.
4. All records kept by the CP program shall be made readily available to the Colorado Department of Public Health and Environment within 30 minutes of their request.
5. The Community Paramedic program will adhere to the personnel records policy of the Eagle County Paramedic Services Policy and Procedure manual. This shall include:
 - a. All personnel qualifications and licenses
 - b. Certifications
 - c. Endorsements
 - d. Registrations
 - e. Training and education
 - f. Evaluations
 - g. Documentations of the employee's orientation to the agency
 - h. Job descriptions
 - i. Annual performance evaluation

Annual Reporting	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to outline annual reporting requirements ECPS will submit to the Colorado Department of Health and Human Services.

Policy:

1. Within forty-five (45) days after the annual license expiration, ECPS shall submit the following information
 - a. The number of persons served by ECPS for the annual reporting period.
 - b. The types of services ECPS provided.
 - c. The types of providers utilized by ECPS, including whether they hold any licenses, registrations or certifications.
 - d. The number of visits performed by each provider type.
 - e. The number of patients who received community integrated health care services from a single visit.
 - f. The number of patients who received community integrated health care services from recurrent visits.
 - g. An evaluation and determination of whether ECPS meets the needs it identified in its community needs assessment.
 - h. A measurement of any reduction in visits to an emergency department for non-emergency, non-urgent medical assistance by patients served by the ECPS CP program.
 - i. The results of any ECPS CP performance reviews received from patients and collaborative partners.

Administrator, Medical Director And Other Staff	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to outline the qualifications for the administrator, medical director and other staff.

Policy:

A. Administrator

1. The administrator shall:
 - a. Be at least 21 years of age and of good moral character.
 - b. Be qualified by education, knowledge and experience to oversee the CP program and services provided.
 - c. Have at least two (2) years health care, emergency medical service agency or health service administration experience with at least one (1) year of supervisory experience in home care, emergency medical services or a closely related health program.
2. Responsibilities – The administrator shall assume authority for the CP program’s business operations including, but not limited to:
 - a. Managing the business affairs and the overall operation of the CP program.
 - b. Organizing and directing the CP program’s ongoing functions.
 - c. Overseeing a budgeting and accounting system.
 - d. Designating in writing a qualified backup administrator to act in the administrator’s absence.
 - e. Maintaining availability of a qualified administrator at all hours employees are providing services.
 - f. Ensuring the CP program’s health care services are in compliance with all applicable federal, state and local laws.
 - g. Ensuring the completion, maintenance and submission of such reports and records as required by the CDPHE.
 - h. Providing ongoing liaison with the CP program’s providers, staff members and the community.
 - i. Establishing a current organizational chart to show lines of authority down to the consumer level.
 - j. Maintaining appropriate personnel records, financial and administrative records and all policies and procedures for the program.
 - k. Ensuring that marketing, advertising and promotional information accurately represents ECPS’s CP program, and addresses the care, treatment and services that the program can provide directly or through contractual arrangement.

- I. Hiring and employing or contracting with sufficient qualified personnel to operate ECPS's CP program's services in accordance with:
 1. Written job descriptions.
 2. Applicable licensing, certification or registration requirements in compliance with federal, state and local laws.
 3. Each CP's scope of practice.
 4. The provisions of Sections 26-3.1-111(6), C.R.S., on or after January 1, 2019. Prior to hiring or contracting with a person who will provide direct care to an at-risk adult, the administrator shall ensure that it has required each prospective CP program employee and contractor to submit to a CAPS Check.
 3. The administrator shall, in collaboration with the CP program's medical director:
 - a. Ensure appropriate education, supervision and evaluation of the program's staff.
 - b. Designate through policy a backup for medical control when the medical director is unavailable.
 - c. Develop and implement a quality management program for the CP program and provider services.
- B. Medical Director
1. ECPS may employ or contract with an APN and physician medical director to serve as co-medical directors for the CP program. ECPS shall clearly delineate and document the CP program providers over whom each co-medical director retains supervisory and medical direction oversight.
 2. Qualifications:
 - a. Physician medical director must:
 - i. Be a physician currently licensed in good standing to practice medicine in the State of Colorado.
 - ii. Possess authority under their licensure to perform all medical acts to which they extend their authority to the CP providers.
 - iii. Satisfy all requirements mandated in 6 CCR 1015-3, Chapter 2 if the medical director also serves as an EMS agency medical director.
 - b. Advanced Practice Registered Nurse (APN) medical directors:
 - i. Must be currently licensed in good standing to practice advanced practice nursing in the State of Colorado.
 - ii. Must possess authority under their licensure to perform all nursing functions and delegated medical functions in accordance with accepted practice standards for which they extend their authority to non-Community Paramedic-endorsed CIHCS providers.
 - iii. Must not be a medical director for a Community Paramedic-endorsed provider delivering medical services
 - iv. May only issue standing orders and protocols as authorized by law.
 3. Responsibilities
 - a. ECPS CP program shall ensure that all CP medical directors perform the following responsibilities and duties.

- i. Be actively involved in the provision of CP services within the community served by the CP program. This could include collaboration with the community served by the CP program, the hospital community, the public safety agencies, home care, hospice, the medical community and should include other aspects of liaison oversight and communication expected in the supervision of CP providers.
 - ii. Be actively involved on a regular basis with the CP program providers. This involvement shall include, at minimum, overseeing continuing education, provider supervision, care and service audits, developing protocols and/or treatment policies and procedures.
 - iii. In collaboration with the administrator, develop a quality management program.
 - iv. Participate in the supervision and evaluation of the performance of CP providers. This includes ensuring the CP providers have adequate clinical knowledge of, and are competent in performing medical skills and acts performed on behalf of the CP program and within the provider's scope of practice and in accordance with state licensure, certification or registration requirements.
 - v. In collaboration with the administrator, oversee training and education programs for CP personnel regarding the provision of out-of-hospital medical services.
 - vi. Notify the CDPHE within fourteen (14) business days of changes to the medical director's position, including cessation of duties as the medical director for the CP program.
 - vii. In collaboration with the administrator, designate a backup for medical direction.
 - viii. Establish governing the CP program services that can be provided to a patient on a single visit.
 - ix. If applicable, develop, monitor and evaluate service plans with the patient's primary care provider.
 - x. When implementing the service plan, ensure that the patient chart reviews are performed in compliance with the quality management plan to determine if appropriate assessments, referrals, documentations and communications are occurring between the care providers, the CP providers and the patient.
 - xi. If applicable, in conjunction with the service plan, develop and implement discharge summaries as part of each patient's service plan.
4. Additional medical director responsibilities:
- a. Develop protocols and standing orders which are appropriate for the care and services offered by the CP program and conform to the certification, skill level and scope of practice of each CP provider type.
 - b. Conduct a review of the protocols and standing orders on an annual basis.

- c. Retain ultimate authority for establishing all protocols and standing orders pertaining to the CP services provided by CP personnel.
- d. Oversee the training, knowledge and competency of endorsed Community Paramedics under his or her supervision and ensure that CP's are appropriately trained and demonstrate ongoing competency in all skills, procedures and medication administration and management.
- e. Ensure that appropriate additional education and training is provided to supervised Community Paramedics and understand that certain skills, procedures and medications authorized may not be included in the education and training of CP's.
- f. Retain ultimate authority and responsibility for monitoring, supervising, evaluating and ensuring the competency of Community Paramedics in the delivery of care and services and the performance of authorized medical acts.

C. Staff and CP providers

- 1. The CP program shall ensure that each employee or contracted staff possesses the education, good moral character and experience to provide services in the homes of patients in accordance with ECPS policy, these regulatory requirements, state practice acts and professional standards of practice.
- 2. The CP program shall ensure its providers and other relevant staff receive appropriate trainings.
- 3. The CP program shall develop and implement a provider training policy.
- 4. All training and continuing education shall be documented and retained by the CP program.

CP Provider Responsibilities	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to outline the responsibilities of the CP provider.

Policy:

1. The CP, acting within the scope of their practice shall:
 - a. Participate as part of a community based team to provide integrated out-of-hospital medical services to address a patient's particular non-urgent medical condition.
 - b. Provide information to the patient about relevant local community resources and other collaborative services.
 - c. Prepare clinical notes, coordinate services, communicate appropriate medical status and treatment information to the patient and/or designated representative and, if applicable, the patient's care provider.
 - d. Comply with all ECPS CP program reporting requirements.

CP Provider Scope of Practice	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to outline the CP scope of practice.

Policy:

- A. Community Paramedics scope of practice when providing out-of-hospital medical services based on behalf of the ECPS CP program.
 1. Under the supervision and direction of the CP programs physician medical director, an endorsed Community Paramedic may, in addition to performing his or her other authorized activities within the paramedic scope of practice, perform the following medical tasks and procedures:
 - a. An initial assessment of the patient and any subsequent assessments as needed.
 - b. Medical interventions that are deemed permissible tasks and procedures promulgated in 6 CCR 1015-3, Chapter Two.
 - c. Care coordination
 - d. Resource navigation
 - e. Patient education
 - f. Inventory, compliance and administration of medications conducted within the rules as promulgated in 6 CCR 1015-3, Chapter Two
 - g. Gathering of laboratory and diagnostic data conducted within the rules promulgated in 6 CCR 1015-3 Chapter Two
 - h. Other community Paramedic tasks and procedures as promulgated within the rules of 6 CCR 1015-3, Chapter Two.
 2. Any services provided must not exceed the scope of practice of the Community Paramedic
 3. EMS providers who are not endorsed Community Paramedics are prohibited from providing out-of-hospital medical services to a consumer when employed by or contracting with the ECPS CP program, except that, in their capacity as ECPS providers, unendorsed EMS providers may perform:
 - a. Ancillary non-medical services with respect to non-emergent conditions
 - b. Any of the services that may be provided through a CARES Program.
 4. Other ECPS providers:
 - a. Under the supervision and direction of the ECPS CP MD, an ECPS CP provider who holds a license, registration or certificate to practice a profession in good standing may perform the authorized activities and skills listed for the provider's license, registration or certificate level on behalf of the CP program within the applicable scope of practice as described in statute or rules.

CP Operations	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to outline operating standards for the ECPS CP program.

Policy:

1. The CP program shall:
 - a. As necessary, refer consumers to a higher level of medical care and/or to other appropriate resources that may assist in the resolution of other issues identified in the initial and subsequent assessments.
 - b. Not utilize its license to circumvent licensing requirements of other facility or agency services.
 - c. Only enroll patients with the reasonable expectation their needs can be met.
 - d. The CP program and patient shall agree to the tasks to be provided and the frequency of visits.
 - e. If the patient's service plan requires care or services to be delivered at specific times, the CP program shall ensure it either employs qualified staff in sufficient quantity or has other effective back-up plans to ensure the needs of the patient are met.
 - f. If applicable for any patient, the CP program shall provide its after-hours contact information and/or with contact information for the CP program's back up-provider.
 - g. In the event of the need to alter the patient's agreed-upon scheduled visits, the patient shall be notified as soon as practicable. If the patient has time-sensitive needs, the CP program shall initiate effective back-up plans to ensure patient safety.
 - h. If there is a missed visit, services shall be provided as agreed upon by the patient and the CP program.
 - i. The CP program shall ensure that its operation and staff utilization will not take away or place any patients at risk or disrupt any the emergency operations ECPS provides.
 - j. The CP program will retain documentation of the minimal qualifications and competencies of the CP MD and administrator.
 - k. The CP program will retain documentation of the qualifications, license and certifications of all its CP providers.
 - l. ECPS CP providers may, if appropriate, use their company vehicle to transport a patient in their care to appropriate destinations other than a hospital or emergency department.
 - m. ECPS CP providers may treat and refer patients with non-emergent conditions to a primary care or urgent care facility.
 - n. ECPS CP providers may assess a patient with a non-emergent condition and communicate with a care provider to determine an appropriate course of action.

Medical Direction Backup	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to outline the backup procedure for when the CP MD is unavailable.

Policy:

1. In the event that the CP MD is unavailable, the ECPS medical director for field operations shall act as the interim CP MD.
2. During times when a CP is on scene with a patient and must reach a physician for orders, questions or any other concerns, the CP will attempt to contact;
 - a. The patients primary care physician (PCP)
 - b. If the PCP is unavailable, the CP will contact the on-call physician at the referring physicians clinic.
 - c. If the on-call physician is unavailable, the CP will contact the Vail Health Emergency Department for medical control.

Community Needs Assessment	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to identify the needs found within the Community Needs Assessment and how the CP program will work to meet these needs.

Policy

1. The ECPS CP program is designed to meet the needs of its residents through the Eagle County Community Health Improvement Plan (2017) by assisting physicians to meet the needs of both their patients and those who have no primary care. CP's will work with the medical providers of Eagle County including, but not limited to, primary care physicians, emergency department physicians, hospitalists, Adult and Child Protective Services and mental health providers to provide the following services under the order of a physician;
 - a. In home ambulatory detox
 - b. Newborn assessments
 - c. History and physical
 - d. INR
 - e. Medication evaluation/management/administration
 - f. Post injury/illness evaluations
 - g. Wound evaluation/dressing changes
 - h. Specimen collection
 - i. Phlebotomy
 - j. Other services ordered by physician through referral

2. Upon receiving a referral, the CP will contact the patient to set up a scheduled visit. After the visit the CP will then document the encounter in the patient care report and this report will be sent securely to the physician. The CP will also work with providers, community outreach services and other entities to meet the unmet needs of the patient. Referrals for additional services will be determined by need during the evaluation of the patient which will include, but not limited to, history and physical, social evaluation, nutrition assessment, medication assessment, depression screening and other evaluations and will be made to services such as, but not limited to;
 - a. Economic services
 - b. The Total Health Alliance
 - c. Food distribution services
 - d. Mental health providers
 - e. Transportation services
 - f. Specialty physicians
 - g. Other services deemed necessary by the CP based on patient need

Administrator Backup	
Adoption Dates: 01/01/2018	Revision Date:
Applies to: All Employees	

Purpose:

The purpose of the policy is to outline the backup procedure for when the CIHCS Administrator is not available.

Policy:

The CIHCS Administrator is the CEO. In the event that the CIHCS Administrator is unavailable, the ECPS chain of command shall act as the interim Administrator Backup. The Community Paramedic Supervisor, Operations Manager and COO are the designated backup. Then the flow shall follow the normal chain of command established in the organization chart.

During times when a CP or patient need help and the Administrator is not available questions should be routed to the designee.



EAGLE COUNTY
PARAMEDIC SERVICES

Community Paramedic Protocols

Winter 2017

TABLE OF CONTENTS

***Administration Protocols*iv**

Eagle County Health and Human Services Referrals..... 10

Home Visitation 12

Medical Direction / Chain of Command 14

Medical Equipment 15

Nurse Practitioner Referrals 16

***MEDICAL PROTOCOLS* 17**

Ambulatory Detox 18

Asthma Management 20

Cpap/Bipap/Sleep Apnea/Oxygen Sat Checks 21

Diabetic Education 22

Follow Up / Post Discharge 23

History and Physical 25

Home Medications 34

Home Safety Assessment 35

Immunizations 36

Intravenous Catheter Changes 37

CoaguChek INR 38

Lab Draw 39

Newborn Home Visit 40

Otoscope 41

Post-partum Visits 42

Social Assessment 43

Well Baby Checks 44

Wound Check / Post-Op Dressing Change 46

References 47

ADMINISTRATION PROTOCOLS

EAGLE COUNTY HEALTH AND HUMAN SERVICES REFERRALS

Policy

The Community Paramedic (CP) program will accept requests from Eagle County Health and Human Services (HHS) Adult and Child Protection caseworkers to assist them on a visit where they believe there is either a known or potentially unmet medical need in the home. In addition, the CP will work with HHS caseworkers to support the Bright-Beginnings and Postpartum home visit programs.

Purpose

To outline two separate types of visits, medical and non-medical. Both visits will use the same referral/order form and the type of visit will be indicated accordingly.

- Adult and Child Protection referrals/orders are considered **medical referrals** and must be signed by the county medical officer. All of these visits will receive a medical examination by the CP.

Procedure

Adult and Child Protection Referrals/Orders

1. The caseworker will fax a copy of the ECPS Community Paramedic referral/order form to the CP office as soon as the need is identified to the requested visit. If an urgent visit is needed during business hours, the caseworker will contact the CP directly.
2. The referral/order form must have the signature of the County Medical Officer.
3. The referral/order must also include the contact information of the caseworker, and if known the identified Primary Care Physician (PCP).
4. The CP office will then contact the caseworker and schedule the visit.
5. If there is an emergent medical needs found upon arrival, the CP will follow the chain of command protocol to get the patient additional medical attention.
6. Subsequent follow up will be coordinated through the patient's caseworker and treating medical provider.

EAGLE COUNTY HEALTH AND HUMAN SERVICES

REFERRALS CONTINUED

Bright Beginnings and Post-Partum Visits

1. The caseworker will fax a copy of the referral form to the CP office one week prior to the requested visit.
2. The CP office will then contact the caseworker and schedule the visit.
3. The CP will visit the home and make sure the client is receiving all the necessary resources to adequately provide for them and their children.
4. Following the visit, the CP will fax a copy of the report to the caseworker within 72 hours of the visit.
5. No report will be faxed to any medical provider because is not a medical visit.
6. If medical needs are identified, the CP will contact the caseworker to obtain an order from the County Medical Officer to perform a more detailed medical exam.

HOME VISITATION

Policy

The Community Paramedic (CP) will provide home visits for patients in response to a medical provider's order.

Purpose

- To outline the standardized procedure of all home visits performed by the CP.
- To describe the difference between initial and repeat visits for the same diagnosis.
- To describe the difference between medical and non-medical/educational visits.

Procedure

Medical Visits

1. Medical provider referrals will be sent to the CP office via fax or email
2. The referral form (depending on which system is used) will include the patient's name, DOB, contact information, diagnosis, reason for visit and medical provider's signature.
3. The CP will access the patient's H&P, visit notes, lab results, and list of current medications through the hospital's electronic medical record system, if available. If not, the CP will request a copy of the patient's record from the medical provider.
4. The CP coordinator will schedule the CP visit with the patient.
5. CP will arrive at the patient's home in an ECPS marked vehicle that is NOT an ambulance.
6. The CP will arrive at the visit wearing an official agency uniform and wearing an ID badge.
7. Upon arrival the CP will have the patient fill out the initial consents and program paperwork.
8. In addition to what is ordered by the medical provider, per protocol, each initial CP visit will receive a complete H&P including V/S and will provide the following as needed:
 - Home safety assessment
 - PEAT scale
 - Social assessment
9. Repeat visits for the same diagnosis will cover what the medical provider orders. The CP will add more services if indicated upon arrival to the patient's home and after the initial assessment is completed.
10. Schedule any follow up visit that are necessary.
11. Upon completion of the visit the CP will document the visit notes in the ECPS electronic patient care record.

12. After completing the report, the CP will send a copy of the patient's care summary to the medical provider within 24 hours. This will include the patient's care report written in SOAP format and any additional services provided by the CP, such as the home safety assessment.

Special Reporting Circumstances

1. If while on scene the CP feels there is a timely issue they need to discuss with the PCP immediately, the CP will attempt to contact them via cell phone at their place of business. If the PCP is not available the CP will then ask to speak with another medical provider at the same facility.
2. If, after leaving the scene, the CP feels the physician needs to be made aware of matter that did not necessarily need to be addressed while they were in the home, however, still needs to be addressed by the physician, the CP will call the facility and leave a message for the provider explaining the issue.
 - a. Note: The CP will understand that leaving a message does not guarantee receipt of that message in a timely manner, and therefore will not leave urgent messages and will instead ask to speak with a provider.
3. If the CP feels that there is something of note that the physician should see in the patient care report, they will call the provider's office and leave a message noting the importance of the report.

Non-Medical / Educational Visits

1. The CP will follow the same procedure as medical visits but without a physical exam or medical services provided
2. Non-Medical / Education visits do not require a medical provider order. The order can come from caseworkers, social workers, school health assistants, etc.
3. The CP visit will cover what services are ordered. If more services are indicated upon arrival, the CP will contact the ordering provider to obtain additional orders.

MEDICAL DIRECTION / CHAIN OF COMMAND

Policy

All Community Paramedics (CP) work in full capacity within their current scope of practice under the medical directors' license for ECPS and more specifically the CP Program.

Purpose

- The Community Paramedic will follow medical provider orders and administering care within the current scope of practice for Colorado (6 CCR 1015-3-Chapter 2).
- The CP report directly through spoken or written dialogue with the patient's referring and primary physician(s).

Procedure

If additional medical needs are identified during a CP visit, the following will occur based on the urgency of care needed:

1. If an emergent medical need is found upon arrival, the CP will call 911 to request an ambulance for immediate transport.
2. If there are any medical needs that do not require immediate transport to a hospital, however, the CP feels the patient should be seen urgently in a medical provider's office, the CP will:
 - First attempt to contact the patient's referring/primary medical provider.
 - Second attempt will be to contact the ordering medical provider's on-call doctor.
 - Third attempt will be to contact the ECPS's Medical Director
 - Fourth attempt will contact the online Medical Control.
 - If unsuccessful, the CP will attempt to make arrangements with the patient to have them transported to an Urgent Care Center.
3. The CP will not accompany the patient in the ambulance unless the responding crew requests their assistance.

MEDICAL EQUIPMENT

Policy

The Community Paramedic will respond to a residence on order from the medical provider requesting a community paramedic to inspect and ensure proper usage of home medical equipment.

Purpose

To assist the medical provider and patient in ensuring efficacy of home medical equipment. This will be done through knowledge of patient history, educating the patient to proper usage, inspection of equipment, assistance in troubleshooting and contacting appropriate resources.

Procedure

1. Obtain and review patient history and medical provider orders prior to appointment.
2. Follow medical provider orders.
3. Inspect equipment
4. Review usage with the patient
5. Troubleshoot if necessary
6. Communicate with medical provider's office
7. Contact medical supply company and provide follow up resources for patient to contact if needed.
8. Document the visit and notify the medical provider's office.
9. Refer patient to PT or OT as needed through PCP

NURSE PRACTITIONER REFERRALS

Policy

When a patient referral is received which has been signed and ordered by a Nurse Practitioner, it is the policy of the ECPS Community Paramedic program that this referral will fall under the general oversight of the Community Paramedic program's medical director.

MEDICAL PROTOCOLS

AMBULATORY DETOX

Policy

The Community Paramedic will respond to the residence of a patient on order from a physician in order to assist with detoxification from alcohol and to assess that the patient is safe and has the necessary resources in place.

The goals of this program are to assess the safety of the patient as they go through the withdrawal process, to evaluate medications for accuracy and compliance, to ensure the patient is receiving adequate social support and to make sure patient is receiving and following up with primary care, mental health professionals and alcohol support groups.

Procedure

- Complete history and physical exam including the following V/S
 - BP
 - HR
 - Respirations
 - Oxygen saturation
 - Temperature
 - Blood glucose
 - Other tests as ordered by physician
- CIWA score
- Medication evaluation and compliance
 - The patient will have been discharged with a set days-worth of detox medication such as Ativan, Librium etc...
 - Assess for compliance of all other medications as well
- Assess for cessation of alcohol
- Depression screen – PHQ-9
- Home safety assessment
- Social support evaluation (support in home from family or others)
- Primary care (if patient referred by hospital, ensure appointment has been made for PCP)
- Mental health (is patient following up with mental health professional)
- Alcohol support group (has the patient made contact with AA or other organization)
- ECPS Community Paramedic ambulatory detox packet of community resources will be given to patient
- Community Paramedic will call the ordering physician to verify that the patient is in compliance with his discharge instructions and the provider will then, if appropriate, call in the refill for the next dose of detox medication
- The next visit will be scheduled for a set number of days following the visit in accordance with the physician orders and length of medication given
- A faxed report will be sent to the physician within 24 hours
- All subsequent follow-up visits will be at the request of the physician as regards to days between visits up to 4 weeks.

- After 4 weeks, if patient is to be continued being seen by the Community Paramedic program, a new referral will need to be submitted

ASTHMA MANAGEMENT

Policy

The Community Paramedic will respond to a residence on request from the medical provider or patient/parent of patient and follow guidelines outlined by the medical providers' orders for the management of asthma.

Purpose

To assist the patient (family/caregiver) by increasing awareness of the disease through education on pathology. To demonstrate and review technique of all devices used to treat asthma. To evaluate and identify home triggers of disease in an effort to lesson exacerbations. To communicate with the medical provider on the general well being of the patient as well as continuing medication reconciliation.

Procedure

1. Obtain and review patient health history and medical provider's orders prior to appointment.
2. Follow medical provider's orders.
3. Educate patient in use of spirometer.
4. Review pathophysiology with the patient
5. Record current patient history including frequency of symptoms at rest, activity and with sleep. Further history will include exacerbating factors including virus exposure, aeroallergen exposure, exercise, cold air, tobacco smoke, chemical irritants etc.
6. Observe home in an effort to possibly identify exacerbating factors.
7. Review devices used by the patient including short/long acting medications and MDI/continuous neb devices.
8. Review when to call health care provider.
9. Communicate all updated information to the medical provider.

CPAP/BIPAP/SLEEP APNEA/OXYGEN SAT CHECKS

Policy

The Community Paramedic will respond to a residence on request from the medical provider and/or patient and follow guidelines outlined by the medical provider's orders for follow up on recently diagnosed and discharged or chronic sufferers of sleep apnea.

Purpose

To assist the medical provider in observing and documenting recently diagnosed/chronic sufferers of obstructive sleep apnea through written and /or verbal communication to ensure proper ventilation of the Patient during sleep for the purpose of avoidance of long term OSA pathologic outcomes.

Procedure

1. Obtain and review patient's health history and medical provider's orders prior to appointment.
2. Follow medical provider's orders.
3. Patient must be closely observed for hemodynamic instability the first 8 hours after starting CPAP/BiPAP
4. Conduct assessment
 - Necessary VS assessments including PO2 and ETCO2 and weight/BMI?
 - Sleep habits (work nights? Irregular work schedule)
 - Alcohol/recreational drug use? Prescription drug use? Compliant?
5. Quality of life - Noticeable changes after usage.
6. Communicate with medical providers' office.
7. Troubleshoot if necessary including ensuring proper fit of mask and use of machine as well as general condition of machine.
8. Connect patient with necessary resources (Oxygen supply company, etc.)
9. Document the visit and notify medical provider's office.

DIABETIC EDUCATION

Policy

The Community Paramedic will respond to a residence on request from the medical provider or patient and follow guidelines outlined by the medical providers' orders to assist in wellbeing checks for the diabetic patient.

Purpose

To ensure the proper maintenance of blood sugar and insulin levels in the diabetic. This will be accomplished through blood glucose monitoring, appropriate prescription drug usage, recognition of desired drug effects, and further education/resources

Procedure

1. Obtain and review patient's health history and medical providers orders prior to appointment.
2. Follow medical provider's orders.
3. Review history and physical exam
4. Review pathology with patient including signs and symptoms of disorder and corrective actions.
5. Receive medical providers' orders including plan for diet, blood glucose levels, and insulin administration.
6. Observe patient's physical state/general wellbeing.
7. Obtain BGL and compare with home glucometer.
8. Note directions for insulin administration and record compliance.
9. Note diet.
10. Note and record patients concerns about treatment (insulin levels, blood sugar levels). Communicate with doctor about request for prescription change.
11. Document the visit and notify medical provider's office.
12. Determine if follow up needed with medical provider and/or community paramedic.

FOLLOW UP / POST DISCHARGE

Policy

The Community Paramedic will respond to a residence on order from the medical provider requesting community paramedic care and follow guidelines outlined by the medical provider's orders for proper follow-up from a medical provider, ER visit, and/or a hospital post discharge.

Purpose

To assist the medical provider in observing and documenting the patients post discharge healing and/or adjustment to new medications, and/or therapy regimen. This will allow for timely adjustment/healing as well as quick identification of unwanted results and alternative direction in care.

Procedure

General Follow-up:

1. Obtain and review patient history and medical provider's orders prior to appointment.
2. Follow medical provider's orders/ discharge pamphlets.
3. Obtain VS including P/BP/RR/temp/and ECG as necessary.
4. Discuss and review with patient the ideal recovery plan, and their current response to treatment.
5. Discuss when to call and follow up with the medical provider.
6. Communicate unusual findings to the medical provider and assist with arrangement of follow up.

Post-injury Follow-up:

1. Review discharge instructions with the patient to make sure they have full understanding of limitations and expectations.
2. Assess patient's pain control and understanding of recommended medications.
3. Assess patient's limited mobility due to the injury. Make recommendations and/or changes in the home environment to decrease chance of further injury.
4. Assess injury site for inflammation. Discuss using ice and non-steroidal anti-inflammatory medications as recommended treatment.
5. Assess ability to care for injury.

Post-stroke Follow-up:

1. Assess patient's understanding of what a stroke is and the short and long term effects
2. Review the discharge instructions with the patient to make sure they have full understanding of limitations and expectations.

3. Review the patient's medication list. Most likely the patient may be taking some or all of the following types of medications: Antithrombotics, ACE Inhibitors, Statins, and/or Diuretics.
4. Review the patient's exercise plan
5. Review the patient's diet plan
6. Discuss the warning signs of stroke
7. Discuss the need to stop smoking, if the patient is a smoker
8. Assess and review the patient's plan for rehabilitation (PT, OT, Speech, home health, etc.)

HISTORY AND PHYSICAL

Policy

The Community Paramedic (CP) will respond to a residence on order from the medical provider requesting CP care and follow guidelines outlined by the medical provider's orders for proper history and physical exam assessments. Note: This policy is an overview of all possible categories of the history and physical. Not all categories need to be assessed or gathered if not applicable to the patient's medical issues.

Purpose

To assist the medical provider in observing and documenting objective and subjective information for the purpose of identifying the patient's state of health and comparing it to the ideal.

Procedure

- Obtain and review patient's health history and medical provider's orders prior to appointment.
- Follow medical provider's orders.
- All information may be recorded prior to paramedic's consultation. It will be decided by the medical provider and paramedic what information to update.

Health History

1. Demographic Data (if not already recorded) that may, if applicable, be collected.
 - Including name, gender, address and telephone #, birth date, birthplace, race, culture, religion, marital status family or significant others living in home, social security number, occupation, contact person, advance directive, durable power of attorney for health care, source of referral, usual source of health care, type of health insurance

Reason for seeking care/ Chief Complaint

1. Present Health Status
 - Current health promotion activities (diet, exercise, etc.), clients perceived level of health, current medications, herbal preparations, type of drug, prescribed by whom, when first prescribed, reason for prescription, dose of med and frequency, clients perception of effectiveness of med.
 - Symptom analysis- location (where are the symptoms), quality (describe characteristics of symptom), quantity (severity of symptom), chronology (when did the symptom start), setting (where are you when the symptom occurs), associated manifestations (do other symptoms occur at the same time), alleviating factors, aggravating factors.

2. Past Health History

- Allergies, childhood illnesses, surgeries, hospitalizations, accidents or injuries, chronic illnesses, immunizations, last examinations, obstetric history

3. Family History

- Develop Genogram
- Family history should include questions about Alzheimer's, Cancer, Diabetes, Heart Disease, Hypertension, Seizures, Emotional problems, Alcoholism/drug use, Mental Illness, Developmental delay, Endocrine diseases, Sickle cell anemia, Kidney disease, Cerebrovascular accident

4. Environmental Assessment

- PEAT scale for all patients on initial visit
- Repeat PEAT scale as need arises

Review of Systems

1. General Health Status

- Fatigue, weakness
- Sleep patterns
- Weight, unexplained loss or gain
- Self-rating of overall health status

2. Integumentary System

- Skin disease, problems, lesions (wounds, sores, ulcers)
- Skin growths, tumors, masses
- Excessive dryness, sweating, odors
- Pigmentation changes or discolorations
- Rashes
- Pruritus
- Frequent bruising
- Texture or temperature change
- Scalp itching
- Hair
 - All body hair, changes in amount, texture, character, distribution
- Nails
 - Changes in texture, color, shape
- Head
 - Headache
 - Past significant trauma
 - Vertigo
 - Syncope
- Eyes
 - Discharge
 - Puritis
 - Lacrimation
 - Pain
 - Visual disturbances

- Swelling
- Redness
- Unusual sensations or twitching
- Vision changes
- Use of corrective or prosthetic devices
- Diplopia
- Photophobia
- Difficulty reading
- Interference with activities of daily living
- Ears
 - Pain
 - Cerumen
 - Infection
 - Discharge
 - Hearing changes
 - Use of prosthetic device
 - Increased sensitivity to environmental noises
 - Change in balance
 - Tinnitus
 - Interference with activities of daily living
- Nose, Nasopharynx, and Paranasal Sinuses
 - Discharge
 - Epistaxis
 - Sneezing
 - Obstruction
 - Sinus pain
 - Postnasal drip
 - Change in ability to smell
 - Snoring
 - Pain over sinuses
- Mouth and Oropharynx
 - Sore throat
 - Tongue or mouth lesion (abscess, sore, ulcer)
 - Bleeding gums
 - Voice changes or hoarseness
 - Use of prosthetic devices (dentures, bridges)
 - Difficulty chewing
- Neck
 - Lymph node enlargement
 - Swelling or masses
 - Pain/tenderness
 - Limitation of movement
 - Stiffness
- Breasts
 - Pain/tenderness
 - Swelling
 - Nipple discharge
 - Changes in nipples

- Lumps, masses, dimples
- Discharge
- 3. Cardiovascular System
 - Heart
 - Palpitations
 - CP
 - Dyspnea
 - Orthopnea
 - Paroxysmal nocturnal dyspnea
 - Peripheral vasculature
 - Coldness/numbness
 - Discoloration
 - Varicose veins
 - Intermittent claudication
 - Paresthesia
 - Leg color changes
- 4. Respiratory System
 - Colds/Virus
 - Cough, nonproductive or productive
 - Hemoptysis
 - Dyspnea
 - Night sweats
 - Wheezing
 - Stridor
 - Pain on inspiration or expiration
 - Smoking history, exposure
- 5. Gastrointestinal System
 - Change in taste
 - Thirst
 - Indigestion or pain associated with eating
 - Pyrosis
 - Dyspepsia
 - Nausea / Vomiting
 - Appetite changes
 - Food intolerance
 - Abdominal pain
 - Jaundice
 - Ascites
 - Bowel habits
 - Flatus
 - Constipation
 - Diarrhea
 - Changes in stool
 - Hemorrhoids
 - Use of digestive or evacuation aids

6. Urinary System

- Characteristics of urine
- Hesitancy
- Urgency
- Change in urinary stream
- Nocturia
- Dysuria
- Flank pain
- Hematuria
- Suprapubic pain
- Dribbling or incontinence
- Polyuria
- Oliguria
- Pyuria

7. Genitalia

- General
 - Lesions
 - Discharges
 - Odors
 - Pain, burning, pruritus
 - Painful intercourse
 - Infertility
- Men
 - Impotence
 - Testicular masses/pain
 - Prostate problems
 - Change in sex drive
 - Penis and scrotum self examination practices
- Women
 - Menstrual history
 - Pregnancy history
 - Amenorrhea
 - Menorrhagia
 - Dysmenorrhea
 - Metrorrhagia (irregular menstruation)
 - Dyspareunia (pain during intercourse)
 - Postcoital bleeding
 - Pelvic pain
 - Genitalia self-examination

8. Musculoskeletal System

- Muscles
 - Twitching, cramping pain
 - Weakness
- Bones and joints
 - Joint swelling, pain, redness, stiffness
 - Joint deformity

- Crepitus
 - Limitations in joint range of motion
 - Interference with activities of daily living
 - Back
 - Back pain
 - Limitations in joint range of motion
 - Interference with activities of daily living
9. Central Nervous System
- History of central nervous system disease
 - Fainting episodes or LOC
 - Seizures
 - Dysphasia
 - Dysarthria
 - Cognitive changes (inability to remember, disorientation to time/place/person, hallucinations)
 - Motor-gait (loss of coordinated movements, ataxia, paralysis, paresis, tic, tremor, spasm, interference with activities of daily living)
 - Sensory-paresthesia, anesthesia, pain
10. Endocrine System
- Changes in pigmentation or texture
 - Changes in or abnormal hair distribution
 - Sudden or unexplained changes in height or weight
 - Intolerance of heat or cold
 - Presence of secondary sex characteristic
 - 3 P's
 - Anorexia
 - Weakness

Psychosocial Status

1. General statement of patient's feelings about self
 - Degree of satisfaction in interpersonal relationships
 - Clients position in-home relationships
 - Most significant relationship
 - Community activities
 - Work or school relationships
 - Family cohesiveness
2. Activities
 - General description of work, leisure and rest distribution
 - Hobbies and methods of relaxation
 - Family demands
 - Ability to accomplish all that is desired during period
3. Cultural or religious practices
4. Occupational history
 - Jobs held in past
 - Current employer
 - Education preparation

- Satisfaction with present and past employment
- 5. Recent changes or stresses in clients life
- 6. Coping strategies for stressful situations
- 7. Changes in personality, behavior, mood
 - Feelings of anxiety or nervousness
 - Feelings of depression
 - Use of medications or other techniques during times of anxiety, stress or depression
- 8. Habits
 - Alcohol / Drugs Use
 - Type of alcohol/drugs
 - Frequency per week
 - Pattern over past 5 years; over the past year
 - Alcohol/drug consumption variances when anxious, stressed, or depressed
 - Driving or other dangerous activities while under the influence
 - High risk groups: Sharing/using unsterilized needles and syringes
 - Smoking / Tobacco Use
 - Type
 - Amount per day
 - Pattern over 5 years; over the past year
 - Usage variances when anxious or stressed
 - Exposure to secondhand smoke
 - Caffeine: Coffee, tea, soda, etc.
 - Amount per day
 - Pattern over 5 years; over the past year
 - Consumption variances when anxious or stressed
 - Physiological effects
 - Other
 - Overeating, sporadic eating or fasting
 - Nail biting
 - Financial status
 - Sources of income
 - Adequacy of income, Recent changes in resources or expenditures

Environmental Health

1. General statement of patients assessment of environmental safety and comfort
2. Hazards of employment (inhalants, noise etc.)
3. Hazards in the home (concern about fire etc.)
4. Hazards in the neighborhood or community (noise, water and air pollution, etc)
5. Hazards of travel (use of seat belts etc.)
6. Travel outside the US

Consider Age-Related Variations in the Health History

1. Newborn
2. Infants

3. Children
4. Adolescents
5. Older Adults

Physical Assessment

1. Techniques
 - Inspection
 - Palpation
 - Percussion
 - Auscultation
2. Positioning
3. Vital Signs
 - Blood pressure
 - Pulse
 - Respirations
 - Oxygen saturation
4. General Assessment
 - Weight
 - Height
 - Skinfold Thickness
5. Age-Related Variations
 - Newborns and Infants
 - Recumbent Length
 - Head Circumference
 - Chest Circumference
 - Vital Signs-Temp, Pulse and Respirations
 - Children
 - Height and Weight
 - Head and Chest Circumference
 - Vital Signs-Temp, Blood pressure
 - Adolescents
 - Weight and Height
 - Older Adults
 - Weight and Height
 - Vital signs
6. Documentation
 - Document all information and communicate with the medical provider.
 - If on evaluation of the patient any of the following S/S are found contact the patient's referring medical provider via phone while still on scene with the patient.
 - Systolic BP > 190 or < 80
 - Diastolic BP > 120
 - Temperature when ordered of > 101.5
 - Pulse at rest > 120
 - Respirations at rest >24
 - O2 sat of < 88% on children < 14 y/o

o O2 sat of < 86 on any patient not on O2

HOME MEDICATIONS

Policy

The Community Paramedic will respond to a residence on order from the medical provider requesting community paramedic care and follow guidelines outlined by the medical provider's orders for home medication checks.

Purpose

- To assist the patient in proper usage of home medications through information/education and vital sign checks.
- To assist the medical provider in a thorough documentation of all prescription and non-prescription medications for the purpose of avoiding adverse drug reactions.
- To ensure proper continuum of care during medical provider care provider transitions.

Procedure

1. Obtain and review patient's health history and medical provider's orders prior to appointment.
2. Follow medical provider's orders.
3. Review history and physical.
4. Review patient's information with the patient, including medical and medication history, current medications the patient is receiving and taking, compliance, time of doses, medical provider who prescribed medications and sources of medications such as the pharmacy.
5. Ask the patient if there are any other medications or supplements they take that might be from another medical provider or over the counter.
6. Assess vital signs
7. Assist patient in sorting medications.
8. Stress importance of medication compliance.
9. Contact referring medical provider if paramedic or patient has concerns.

Document all medications whether prescribed or over the counter and communicate list and current health/reactions to medical provider.

HOME SAFETY ASSESSMENT

Policy

The Community Paramedic will respond to a residence on order from the medical provider requesting community paramedic care and follow guidelines outlined by the medical provider's orders for a home safety assessment.

Purpose

To ensure the home is in safe condition to meet the medical needs of the patient. Can be used to conduct a pre-surgical assessment, post-operative assessment, or an evaluation of the safety of the home at anytime.

Procedure

1. Follow the Home Safety Inspection checklist including the inspection of the following areas of the home:
 - Outside of the house
 - Living room
 - Kitchen
 - Stairs
 - Bathroom
 - Bedroom
 - General Inspection
2. Complete the *Overall Tips* inspection
3. Complete comments on any sections marked "no" during the inspection
4. Complete recommendations for the resident and possible referrals
5. Discuss the findings with the patient and resources to remedy
6. Have the patient sign off the report with the understanding they understand the recommendations
7. Complete report and return a copy to the ordering medical provider.
8. If any life-threatening issues are identified, notify the ordering provider immediately.

IMMUNIZATIONS

Policy

The Community Paramedic will respond to a residence on order from the medical provider requesting community paramedic care and follow guidelines outlined by the medical provider's orders for the purpose of ensuring the healthy physical and mental development of the young community member.

Purpose

To assist the primary medical provider, and/or public health nurse in administering immunizations to prevent disease transmission.

Procedure

1. Obtain medical provider's orders prior to appointment.
2. Obtain and review patient's health history (this includes immunization history, contraindications, health status, and allergies).
3. Obtain immunization in public health with cooler and ensure temperature stays within normal limits for vaccine
4. Obtain necessary paperwork will include the following:
 - 1) Vaccine Information Sheets (VIS)
 - 2) Administrative consent forms
 - 3) Patient's immunization record from one of the following:
 - Patient's medical provider
 - Authorized State of CO Public Health immunization record from CIIS
 - Authorized State of CO school immunization record.
 - International immunization record.
5. Verify the order with the correct vaccine, person, dose, site and time.
6. Administer vaccine through proper route and technique.
7. Observe for adverse reactions for 15 minutes
8. Discuss reactions and educate parents on side effects from the vaccinations
9. If an adverse reaction occurs, follow the ECPS medical protocols.
10. Update immunization record.
11. If sequential vaccines are indicated, refer the patient for follow-up at the medical provider's office or public health clinic.

INTRAVENOUS CATHETER CHANGES

Policy

The Community Paramedic will respond to a residence on order from the primary medical provider requesting community paramedic care and follow guidelines outlined by the medical provider's orders and/or ECPS' medical protocols for the removal and reinsertion of intravenous (IV) catheters.

Purpose

To remove and reinsert IV catheters for the purpose of continuing IV access and avoidance of possible local and systemic infections and/or patient discomfort.

Procedure

1. Obtain and review patient's health history and medical provider's orders prior to appointment.
2. Follow ECPS' medical protocols for IV access.
3. Be cognizant of complications of long-term catheter use and effects of termination of IV. Educate patient on signs of infection.
4. Take into account certain medications, which could lead to uncontrolled bleeding.
5. Communicate any unusual findings with medical provider.

COAGUCHEK INR

Policy

The Community Paramedic will respond to a residence on request from the medical provider and follow guidelines outlined by the medical provider's orders for obtaining an INR level.

Purpose

To assist the medical provider in obtaining certain blood laboratory values while in the patients home.

Procedure

1. Using BSI technique, apply drop of blood to the test strip.
2. The CP will report the INR level to the referring physician.
3. The CP will instruct the patient not to change any medication dosing until ordered to do so by the physician.

LAB DRAW

Policy

The Community Paramedic will respond to a residence on order from the medical provider requesting community paramedic care and follow guidelines outlined by the medical provider's orders for the purpose of obtaining a lab specimen for testing.

Purpose

To assist the medical provider in obtaining specimens for appropriate diagnostic and testing procedures. By performing the lab draws in the home, it prevents the patients from needing to go into a medical provider's office for a minor procedure that can be managed by the Community Paramedic.

Procedure

1. Perform lab draw
2. Tubes should be collected in the order of red, green, purple, pink, and blue.
3. Fill out the label for each of the tubes to include the patient's name, date of birth, provider's initials, and date and time of the lab draw.
4. Affix the label to the blood tubes
5. If necessary, complete the lab paperwork provided by the medical provider's office or hospital
6. Put samples in a biohazard bag
7. Deliver samples to the appropriate ordering medical provider's office or hospital as ordered

NEWBORN HOME VISIT

Policy

The Community Paramedic will respond to a residence on order from the medical provider requesting a visit to the home of a newborn with the goal being 7 – 10 days post birth.

Purpose

To assist the medical provider by observing and documenting the transition from the hospital, social environment, safety and general well-being of the newborn in the home with the goal of a visit between 7 and 14 days post birth.

Procedure

1. The paramedic will assess the following areas while in the home:
 - A. History and physical of the newborn including oxygen saturation and weight.
 1. Any of the following V/S findings require immediate transport of the newborn to the emergency department:
 - a. Temperature >100.5
 - b. HR > 200 that is persistent at rest or sleep without crying
 - B. Calculation of weight loss from both birth and discharge date
 - C. Crib safety including sleep safety
 - D. General home safety
 - E. Social evaluation
 - F. Nutrition assessment of both mother and newborn
 - G. Postpartum screen of mother
 - H. Need for additional resources in the home
 - I. Any other service ordered on the referral
2. Upon completion of the call the Community Paramedic will fax the patient care report to the primary care physician who is caring for the infant.
3. If there are any concerns the CP will follow the 'Special reporting circumstances' section of the Home Visitation policy.

OTOSCOPE

Policy

The Community Paramedic will respond to a residence on order from the medical provider requesting community paramedic care and follow guidelines outlined by the medical provider's orders for the purpose of ensuring proper healing of a patient with an ear infection.

Purpose

To assist the medical provider in observing and documenting the patient's response to medical care through follow up visual inspection of patient's ear.

Procedure

Adult

1. Use otoscope with largest ear speculum that ear canal will accommodate.
2. Position the patient's head and neck upright.
3. Grasp auricle firmly and gently pull upwards, backward and slightly away from head.
4. Hold otoscope handle between thumb and fingers and brace hand against patients face.
5. Insert speculum into ear canal, directing it somewhat down and forward and through hairs.
6. Inspect ear canal noting discharge, foreign bodies, redness and/or swelling.
7. Inspect eardrum noting color and contour and perforations.

Child

1. Child may sit up or lie down.
2. Hold otoscope with handle pointing down toward child's feet, while pulling up on auricle.
3. Hold the head and pull up on auricle with one hand, while holding otoscope with other hand.
4. See adult inspection above for inspecting canal and eardrum.

Findings

- Acute otitis media is common in children and presents with red, bulging tympanic membrane with dull or absent light reflex. Purulent material may also be seen behind tympanic membrane.

POST-PARTUM VISITS

Policy

The Community Paramedic (CP) will respond to a residence on the request of the provider to perform a postpartum check of the mother and to assess the newborn.

Purpose

To assess both the newborn and mother in the home and to determine if there are any unmet medical needs. To see if there is any further education that needs to be done and to provide mother and family with any information on services that could be helpful.

Procedure

1. Perform a general H&P on newborn which includes:
 - Weight
 - Oxygen saturation check
 - V/S including pulse, heart tones, respirations
 - Physical examination
2. Review of mother's post-delivery health and well being
3. Evaluate mother for postpartum depression and discuss warning signs
4. PEAT scale
5. Home safety assessment with the following additions:
 - Safe sleeping recommendations for the newborn
 - Newborn equipment safety check
 - Car seat check
6. Nutrition evaluation of both mother and newborn
7. Social evaluation
8. CP will send report of all findings to both the referring provider and also to the patients PCP if different from referring provider within 24 hours of visit.

SOCIAL ASSESSMENT

Policy

The Community Paramedic (CP) will respond to the home on the request of the provider to perform a social assessment.

Purpose

To assess the social environment in which the patient lives. This will enable the CP to determine if adequate support systems are in place and to offer any assistance in providing the patient with available resources that are wanted and/or needed. This will also allow the paramedic to assess the basic financial needs of the home and be able to link the patient in with possible assistance programs.

Policy

1. The CP will complete the 'Social Evaluation Checklist' through an interview with the patient.
2. The CP will then fax a completed copy of the report to the referring provider within 24 hours of the visit.
3. The CP will notify the CP Coordinator of any potential unmet needs and the coordinator will then be responsible for following up with the appropriate resources and relaying this information back to both the provider and the patient.

WELL BABY CHECKS

Policy

The Community Paramedic (CP) will respond to a residence on order from the medical provider requesting CP care and follow guidelines outlined by the medical provider's orders for the purpose of ensuring the healthy physical and mental development of the young community member.

Purpose

To assist the medical provider in observing and documenting height and weight gain as well as recognizing proportionality for the healthy development of the child. To provide/assist in immunizations and/or blood testing for the purpose of preventing disease and/or determining physiological and biochemical states for the early detection of disease.

Procedure

1. Well baby checks are advised for the following ages: 2-4 weeks, then every 2 months until 6-7 months, then every 3 months until 18 months, then 2 years, 3 years, at preschool, and every 2 years after.
2. Obtain and review patient's health history and medical provider's orders prior to appointment.
3. Follow medical provider's orders.
4. Developmental assessment:
 - Denver II
5. Obtain Patient health history:
 - Note diet, feedings, mother-child interactions, signs of neglect, signs of physical abuse or obvious physical illness such as diarrhea or chronic infection.
 - Calorie count should be done to ensure adequate caloric intake.
 - Prenatal care/ health prior to birth/labor and delivery/growth/development?
6. Head to toe assessment
 - General appearance
 - Skin
 - Variations of color, texture, temp, turgor, accessory structures
 - Lymph Nodes
 - Head
 - Neck
 - Eyes
 - Internal/external exam

- Use Ophthalmoscope
- Ears
 - Internal/external exam
 - Use Otoscope
- Nose
 - Internal/external exam
- Mouth and Throat
 - Internal/external exam
- Chest
- Lungs
 - Inspection, palpation, percussion, auscultation
- Heart
 - Inspection, palpation, auscultation

WOUND CHECK / POST-OP DRESSING CHANGE

Policy

The Community Paramedic will respond to a residence on order from the medical provider requesting community paramedic care and follow guidelines outlined by the medical provider's orders for the purpose of wound care and post-operative dressing changes.

Purpose

To assist the medical provider in attending to soft tissue injuries for the purpose of restoration of function through repair of injured tissue while minimizing risk of infection and cosmetic deformity. This will be accomplished through visual inspection, wound cleaning and dressing/bandage change, and patient education.

Procedure

1. Obtain patient history including history of wound, medical illnesses (certain illnesses may delay wound healing and increase risk of infection), current vaccinations (Tdap) and medical provider's orders.
2. Obtain VS including P/BP/RR/Temp and ECG as necessary.
3. Visually inspect dressings and wound.
 - Examine dressings for excess drainage.
 - Examine wounds for infection and delayed healing including increasing inflammation, purulent drainage, foul odor, persistent pain, and fever.
 - If needed, document wound with digital camera and send to medical provider with updated records.
4. If signs of infection, contact medical provider immediately for follow up.
5. If no signs of infection clean and dress wound per medical provider's orders, and educate patient on signs and symptoms of infection and risk management.
6. Make sure patient is up to date on vaccinations (Tetanus) and if needed offer vaccine on sight or connect to public health.
7. Record required information and connect with medical provider.

REFERENCES

The policies and procedures were compiled using the following references:

- Bickley, Lynn S, MD. Bates' Guide to Physical Examination and History Taking. 10th ed. Philadelphia, PA: Wolters Kluwer Health / Lippincott, Williams, & Wilkins, 2009.
- Giddens, Jean Foret, and Susan F. Wilson. Health Assessment for Nursing Practice. 2nd ed. St Louis, MO: Mosby, 2001.
- Graber, Mark A, Jennifer L. Jones, Jason K. Wilbur. The Family Medicine Handbook. 5th ed. Philadelphia, PA: Mosby, 2006.
- Hockenberry, Marilyn J. Nursing care of infants and children. 7th ed. St. Louis, MO: Mosby, 2003.
- Lowdermilk, Deitra Leonard, and Shannon E. Perry. Maternity and women's health care. 8th ed. St. Louis, MO: Mosby, 2004.
- "The physician's role in medication reconciliation." American Medical Association. 2007. <http://www.ama-assn.org/ama1/pub/upload/mm/.../med-rec-mongraph.pdf>.
- Sanders, Mick J. Mosby's Paramedic Textbook. 3rd ed. St Louis, MO: Mosby, 2005.
- Wilkinson, Judith and Treas, Leslie. Fundamentals of Nursing – Volume 1: Theory, Concepts, and Applications. 2nd ed. Philadelphia, PA: F. A. Davis, 2010.



Community Paramedic Quality Review Form

Patient name: _____ CP provider _____

Incident number: _____ Date of visit _____

Date of referral _____ Response appropriate _____ Date of Chart Audit __9/05/2017

1. Medical provider referral on the chart for every visit? Y / N
2. Patient chrono attached and utilized? Y / N
3. Physician summary attached? Y / N
4. Are all of the MD orders documented in the PCR? Y / N
5. Are all of the patient/client contacts documented in the chart? Y / N
6. Assessments completed and if so documented? Y / N
7. Previous CP visits? Y / N
8. Did the CP follow up on any previous abnormal findings? Y / N/ NA
9. Home health and HIPAA paperwork completed Y / N
10. Is the H&P from the primary care physician included with chart? Y / N
11. Accessed by Cerner? Y / N
12. Did patient receive admission packet/Privacy notice? Y/N
13. Prevented further treatment? Y/N/NA
 - a. ED visit
 - b. Hospital admission
 - c. Office visit
 - d. Ambulance call
 - e. Skilled Nursing Facility
14. Are the following PCR fields completed:

<input type="checkbox"/> Name of CP Responder	<input type="checkbox"/> Patient name
<input type="checkbox"/> Provider Making Referral	<input type="checkbox"/> Date of Call
<input type="checkbox"/> Medical Home/Primary provider	<input type="checkbox"/> Type of Insurance
<input type="checkbox"/> Services Ordered	<input type="checkbox"/> Additional Services Provided
<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Recently Hospitalized?
<input type="checkbox"/> Recommended Referral	<input type="checkbox"/> Race/Ethnicity
<input type="checkbox"/> Language	<input type="checkbox"/> Age/DOB
<input type="checkbox"/> Gender	<input type="checkbox"/> Home Address
<input type="checkbox"/> Mailing Address	

Comments: _____

Audit Completed by Jeri Lu Atkins, MD, Medical Director

MD signature: _____

Reviewed: Marc A. Burdick, Quality Manager

APPENDIX 9

DEVELOP A DATA COLLECTION PROCESS

9.1 – CP PATIENT DATA TEMPLATE

Demographics										
Patient Identifier	Date of Service	No. of Patients	No. of Visits	Age	Gender	Ethnicity	Primary Language	City	State	Zip
		No. of Patients	No of Visits							
		0	0							

Primary Care				Type of Insurance	
YES	NO	Agency Making Referral	Provider Making Referral	Primary	Secondary

0 0

Eagle County Paramedics: July 1,

Newborn	Prevention Visit	Other	ICD-9 Code	ICD-10 Code
		Other		

#REF!

2012 - November 30, 2013 Evaluation Tracker

2012 - November 30, 2013 Evaluation Tracker										
NOTES	Respiratory Function	BP Check	INR	Cardiac Function	Ability to Ambulate	Neuro-logical Assessment	Blood Draw	UA	Blood Glucose Level	Diabetic FU/ED
	Respiratory Function				Ability to Ambulate	Neuro-logical Assessment	Blood Draw		Blood Glucose Level	Diabetic FU/ED
	0				0	0	0		0	0



Services Provided (Medical Provider's Order)

Medication Eval	Home Safety Assessment	Welfare Check	Weight Check	Post illness or injury FU	Hospital Discharge FU	Social Eval	Wound Eval	Mental Health Eval	Nutrition Assess.	Prevention
Medication Eval			Weight Check		Discharge FU		Wound Eval		Nutrition Assess.	Prevention

0

0

0

0

0



Prevented Level of Service:

Other	Notes	Physician Office	Ambi Transport	ER Visit	Skilled nursing	Hospital Admission



Doctor	Ambi	ER	skilled	Hospital
#REF!	#REF!	#REF!	nursing #REF!	0

Referral											
Referral			Recent Hospitalization in the last 6 months				Providing services that they wouldn't have		Are services being provided at a more appropriate care		
YES	NO	Where	YES	NO	DATE	Related	YES	NO	YES	NO	Overall Notes

0 0

APPENDIX 10

BEGIN OPERATIONS

10.1 – REFERRAL FORM

10.2 – SAMPLE PATIENT CARE CHART/REPORT

10.3 – MOU SAMPLE AND IGA SAMPLE

10.4 – PATIENT CHRONOLOGY SAMPLE



Community Paramedic Patient Order Form

PATIENT INFORMATION <small>(May submit patient face sheet for demographics)</small>					PLEASE RETURN BY FAX TO 866-623-9948				
Date of Order:		Requested Date of Service:			Primary Language:				
Client Name: Last		First		Middle		DOB:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	
Physical Street Address			City/Town		State		Zip Code		Phone Number
Mailing Address (if different)			City/Town		State		Zip Code		Secondary Phone
Insurance (For research purposes only): <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, company: _____									
DIAGNOSIS					PREVENTION ASSESSMENTS				
Diagnosis : _____					<input type="checkbox"/> Nutrition Assessment <input type="checkbox"/> Social Evaluation / Social Support <input type="checkbox"/> Home Safety Inspection				
Reason for Visit: _____									
LABORATORY SPECIMEN COLLECTION					PLEASE INCLUDE AGENCY CLINICAL LAB TESTING ORDER SHEET				
<input type="checkbox"/> Blood Draw		<input type="checkbox"/> iStat Test		<input type="checkbox"/> Stool Collection		<input type="checkbox"/> Urine Collection			
Requested Labs/Blood Tubes: _____									
CLINICAL CARE									
<u>Cardiovascular</u>			<u>Respiratory</u>			<u>General</u>			
<input type="checkbox"/> Blood Pressure Check			<input type="checkbox"/> Asthma Meds/Education/Compliance			<input type="checkbox"/> Assessment / H&P			
<input type="checkbox"/> EKG 12 Lead			<input type="checkbox"/> CPAP			<input type="checkbox"/> Ear exams			
<input type="checkbox"/> Peripheral Intravenous Lines			<input type="checkbox"/> MDI Use			<input type="checkbox"/> Medication Evaluation or Medication Compliance			
<u>Follow-up/Post Discharge</u>			<input type="checkbox"/> Nebulizer Usage/Compliance			<input type="checkbox"/> Post Injury/Illness Evaluation			
<input type="checkbox"/> Diabetic Follow-up/Education			<input type="checkbox"/> Peak Flow Meter Education/Usage			<input type="checkbox"/> Ambulatory detox			
<input type="checkbox"/> Neurological Assessment			<input type="checkbox"/> Oxygen Saturation Check			<input type="checkbox"/> Weight Check			
<input type="checkbox"/> Dressing Change/Wound Check/Type: _____									
<input type="checkbox"/> Discharge Follow-up/Diagnosis: _____									
Other Orders/Information: _____ _____									
PUBLIC HEALTH/SOCIAL SERVICES/ADULT PROTECTION									
<input type="checkbox"/> Bright Beginnings		<input type="checkbox"/> EHS Post Partum Visit		<input type="checkbox"/> Fluoride Varnish Clinic		<input type="checkbox"/> Welfare Check/Medical Assessment			
<input type="checkbox"/> Disease Investigation		<input type="checkbox"/> IZ Clinic Coverage		<input type="checkbox"/> TB Meds DOT					
ORDERING PHYSICIAN SIGNATURE (MUST BE SIGNED)					Disclaimer: All visits will be accomplished as soon as possible but generally within 24 – 72. All services provided must be within the scope of practice of a paramedic as described in 6 CCR 1015-3 Chapter 2, EMS Practice and Medical Director Oversight Rules. Paramedics will verify that orders fall within this scope of practice and will contact you if orders need clarification or further instruction.				
Contact Number: _____									
Referring Physician: _____ <small>(Please Print)</small>									
_____ Signature			_____ Date						
<input type="checkbox"/> Fax report back to referring physician <input type="checkbox"/> Fax report to: _____									



EAGLE COUNTY
PARAMEDIC SERVICES

Email : communityparamedic@ecparamedics.com
Phone : 970-926-5270
Fax : 1-866-623-9948

Community Paramedic Program Physician Referral Summary

Patient name:

DOB:

Date of visit:

Summary report:

Completed by:

INTERGOVERNMENTAL AGREEMENT COMMUNITY PARAMEDIC PROGRAM

This Community Paramedic Program Agreement (“Agreement”) is entered this day of _____, 20____, between _____ (“_____”) and _____ (“_____”), herein being referred to as “Participants”.

WHEREAS, the Participants share a mission to improve the health of residents in _____ County; and

WHEREAS, the Participants have established a strategic, seamless health care delivery system utilizes paramedics to provide specific primary care and prevention services in the home and other community settings; and

WHEREAS, the Participants seek to increase access to health care services for _____ County residents that are un-or-underinsured, Medicaid and Medicare populations; and

WHEREAS, the Participants intend to accomplish the following health related outcomes: 1) Reduce the number of unnecessary re-hospitalizations for program participants; 2) Ensure all patients in the program have a medical home; 3) Reduce the amount of health care dollars spent on preventable conditions that could otherwise require ongoing hospital care; 4) Reduce the number of seniors injured in falls, through in-home injury prevention strategies; and 5) Increase access to public health services such as vaccinations and fluoride varnish.

WHEREAS, the Participants clarify roles and responsibilities of the Participants to ensure strategic operations including, but not limited to: 1) Effective communication and coordination; 2) Consistent provision of quality services that meet the needs of participants who are jointly served; 3) Efficiencies by maximizing shared personnel, resources and services; and 4) Measure and monitor processes and impacts to accurately measure outcomes and establish an international model.

WHEREAS, _____’s is lead administrator of the program including, but not limited to acting as fiscal agent; supervising the program coordinator, paramedics, and any other program positions; and contracting with a physician for medical oversight.

WHEREAS, _____ is a strategic partner and will contribute no additional funds at this time. Resources provided include limited staff time based on appropriate expertise.

NOW, THEREFORE, in consideration of the terms and conditions of this Agreement, the Participants shall have the following joint responsibilities:

I. Leadership

_____ and _____ as partners in the Community Paramedic program shall provide leadership to the program by networking with relevant community organizations, presenting information to other health professionals around the state for program replication,

participating in joint meetings with the program coordinator, and overseeing an advisory committee of health care experts who will provide input into the program.

II. Training

_____’s primary role includes, but is not limited to, providing the Community Paramedic student training, (in conjunction with the _____ College), and coordinating student clinical rotations with local health care providers.

_____ shall coordinate student trainings of relevant topics within the public health field, and how to link patients with health and human services, plus precept students in such clinical services as vaccinations, fluoride varnishing, and disease investigations.

III. Policy and Procedure Development

_____ shall develop policies, procedures and protocols for the program to assure the quality of services.

_____’s nursing and quality assurance expert will assist other community partners with review of such documents and provide input, based on the community paramedic’s role within the scope of the public health agency, such as prevention activities within the home and community and linking of patients to resources.

IV. Backfill and Surge Capacity

_____ shall make the Community Paramedics available to _____ to assist with medical and prevention activities for which they’ve been trained, such as immunizations, distribution of medication, and communicable disease interviewing, during public health emergencies and/or public health staffing shortages.

V. Public Health Clinic Participation

_____ will make the Community Paramedics available to assist _____ up to two days per month with clinical services such as immunizations, fluoride varnish applications, and other related services in order to increase the number of clients able to be served within the _____ County community, under no financial obligation to _____.

Insurance:

Each party, shall, at no cost or expense to the other party, carry a policy or policies of professional liability insurance, comprehensive general insurance, and workers compensation insurance issued by an insurance carrier or self insurance mechanism authorized by the State of Colorado in such amounts as are reasonably acceptable to each other, provided that such amounts are not less than the liability limitations under the _____. If the liability insurance required by this section is on a “claims made” basis and at any time prior to the expiration of any statute or limitation period which might apply to acts, errors or omissions of the provider during the term of this Agreement, a party shall cease to maintain liability insurance required by this section or should switch insurance carriers, that party shall purchase from an insurance carrier acceptable to the other, a “tail” policy covering acts, errors or omissions during the term of this Agreement as to which claims may then still be asserted. The parties agree promptly to furnish to each other evidence reasonably satisfactory to the other party of the maintenance and continued effectiveness of the insurance required by this section. If a party fails to purchase such tail coverage within 30 days after the termination of this Agreement, the other

party shall have the right to purchase such coverage and bill the other for the premium. Each party shall obtain an endorsement on their respective insurance policies listing the other as a named or additional insured.

Upon request, each party shall provide the other with certificate(s) of such insurance coverage and statement(s) from the insurance carrier that the certificate holder will be notified at least 30 days prior to any cancellation, non-renewal or change in such coverage. Failure by either party to maintain proper insurance coverage shall, at the option of either party, be grounds to immediately terminate this Agreement.

Nothing in this Agreement shall constitute a waiver.

Termination of Agreement: This Agreement may be terminated by in writing with thirty (30) days notice signed by either party.

Amendment:

This Agreement shall be binding on the Participants and represents the final and complete understanding of the Participants as regards the subject matter. This Agreement shall not be modified or amended unless in writing, executed by Participants.

Waiver of Breach:

No waiver by either party of any term, covenant, condition or agreement contained herein, shall be deemed as a waiver of any other term, covenant, condition or agreement, nor a waiver of breach thereof deemed to constitute a waiver of any subsequent breach, whether of the same or a different provision of this Agreement.

Counterparts:

This Agreement may be executed in counterparts, each of which will be an original, but all of which together shall constitute one and the same instrument.

Enforcement:

This Agreement shall be governed and construed in accordance with the laws of the State of Colorado, and in addition to any other remedy, may be specifically enforced.

IN WITNESS WHEREOF the Participants have caused this Agreement to be executed as of the day and year written above.

By: _____

Title: _____

ATTEST: _____

By: _____

Title: _____

ATTEST: _____

MEMORANDUM OF UNDERSTANDING COMMUNITY PARAMEDIC PROGRAM

This Community Paramedic Program Agreement (“Agreement”) is entered this _____ day of _____, _____, between _____ (“_____”) and _____ (“_____”), herein being referred to collectively as, the “Participants.”

WHEREAS, the Participants share a mission to improve the health of residents in _____; and

WHEREAS, community paramedics are specially trained to conduct in-home patient assessments and provide specific primary health care and preventive services, by acting through a physician’s order and within a defined scope of practice; and

WHEREAS, the community paramedic model helps physicians monitor the health of vulnerable patients, thereby producing better health outcomes and reducing the number of ambulance transports, visits to the emergency department, and hospital readmissions; and

WHEREAS, medical providers are key to the program in terms of providing clinical training and issuing orders; and

WHEREAS, _____ desires to participate in the community paramedic program.

NOW, THEREFORE, in consideration of the terms and conditions of this MOU, the receipt and sufficiency of which is jointly acknowledged, the Participants agree as follows:

I. Scope of Work

- a. Participants agree to share patient records as is necessary to provide care, and will follow corresponding confidentiality policies. The patient record created by the community paramedic will be sent to the ordering physician at _____.
- c. Participants agree to run data requests on certain measurable outcomes for use by both parties. Data will be presented in aggregate without patient identifiers. _____ will share program evaluation results with _____.
- d. _____ providers shall formally request a home visit by the community paramedic through a physician order, based on services that are within the scope and expertise of the paramedic. A community paramedic will act on the order between 8:00 am and 5:00 pm within 48 hours of receipt, and based on urgency and availability, unless otherwise agreed upon by the issuing provider.
- e. _____ may provide a representative to the Community Paramedic Advisory Committee, which meets quarterly.
- f. _____ shall participate in case reviews when appropriate, in order to improve the quality of the program and document specific outcomes for evaluation purposes.

- g. _____ shall provide the medical oversight for the program through its Medical Directors, Minnesota-licensed physicians.
- h. _____ participating physicians shall sign Appendix B agreeing that they understand the program and the procedures available to be performed. Appendix B can be amended with additions or deletions of physician’s signatures on an as needed basis without the need to change this agreement.

II. Term of Agreement

The term of this Agreement shall be through the end of the year in which it is entered, and this Agreement shall be automatically renewed for additional one (1) year terms in perpetuity.

III. Termination of Agreement

This Agreement may be terminated by either party at any time and for any reason in writing with thirty (30) days written notice.

IV. Notices

Any formal notice, demand or request pursuant to this Agreement shall be in writing and shall be deemed properly served, given or made, if delivered in person or sent by certified mail postage prepaid to the Participants at the following addresses or as otherwise modified pursuant to this section:

If to ECHSD:

with a copy to:

If to _____:

with a copy to:

V. Severability

In the event that any of the terms, covenants or conditions of this Agreement or their application shall be held invalid as to any person, entity or circumstance by any court having competent jurisdiction, the remainder of this Agreement and the application in effect of its terms, covenants or conditions to such persons, entities or circumstances shall not be effected thereby.

VI. Section Headings

The section headings in this Agreement are inserted for convenience and are not intended to indicate completely or accurately the contents of the sections they introduce and shall have no bearing on the construction of the sections they introduce.

VII. Duly Authorized Signatories

By execution of this Agreement, the undersigned each individually represent that he or she is duly authorized to execute and deliver this Agreement and that the subject party shall be bound by the signatory's execution of this Agreement.

****SIGNATURES TO FOLLOW****

IN WITNESS WHEREOF the Participants have caused this Agreement to be executed as of the day and year written above.

By: _____

Title: _____

By: _____

Title: _____

Appendix A
 Community Paramedic Clinical Procedures
 Pediatric / Neonatal Clinical Rotation
16 Hours Clinical Time

PROCEDURES LEVEL 1	# Performed	Clinical Site
Well Baby Checks		Ped - C
2 - 12 months	20	Ped - C
1-5 yrs	15	Ped - C
6-13 yrs	10	Ped - C
13-18 yrs	10	Ped - C
Weights	5	Ped - C
Length	5	Ped - C
Head and Circumference	5	Ped - C
Blood Pressure checks	2	Ped - C
Development Assessment	5	Ped - C
Pt Documentation		Ped - C
SOAP Notes	5	Ped - C
Chart Review	15	Ped - C
Acute Illness Management		Ped - C
0-1 years	2	Ped - C
1-5 years	2	Ped - C
6-13 years	2	Ped - C
14-18 years	2	Ped - C

Community Paramedic Clinical Procedures
 Family Practice Clinical Rotation
40 Hours Clinical Time (L1)

PROCEDURES LEVEL 1	# Performed	Clinical Site
Blood Pressure checks	2	FP
Medical Equipment		FP
Otoscope	30	FP
Blue Tooth Stethoscope	5	FP
Home Medication		FP
Compliance	7	FP
Medication Reconciliation	7	FP
Pt Documentation		FP
SOAP Notes	5	FP
Chart Review	15	FP
History & Physical	20	FP
Assessment	20	FP
Results from Tests/Diagnostic tools	15	FP
Identifying Red Flags	5	FP
Identifying further testing needs	5	FP
Prenatal		FP
Doppler	5	FP
Measurements	5	FP
Urine for Protein	5	FP
Acute Illness Management		FP
0-1 years	5	FP
1-5 years	5	FP
6-13 years	5	FP
14-18 years	5	FP
18 + years	5	FP
65 + years	5	FP

APPENDIX 11

DEVELOP A PLAN TO EVALUATE & USE PROGRAM DATA

11.1 – ROI WORKBOOK

11.2 – COMMUNITY PARAMEDIC CQI FORM

11.3 – SAMPLE PATIENT SURVEY

11.4 – MIH METRICS

Return on Investment (ROI) Analysis
Free-standing EMS System

Economic ROI

Investment

Personnel Investment

- Recruitment
- Training
- CP Wages
- CP Benefits
- Support Personnel Wages
- Support Personnel Benefits

Operating Investment

- Non-Capital Equipment
- Supplies
- IT Support
- Continuing Education
- Utilities
- Fuel
- Vehicle Maintenance
- Uniforms
- Other Administrative Expenses

Capital Investment

- Vehicles
- Office Space

Non-Economic ROI

Investment

Research & Development

Return

- Medicaid Fee-For Service Revenue
- Grant Revenue
- ACO Revenue - Negotiated Payments or Share of ACO savings
- Direct Patient Revenue
- Other Contracted Revenue - Employer or other buyer arrangements

Return

- Community Goodwill
- Improved Market Perception/Reputation
- Larger Demonstrated Community Benefit
- Employee Engagement
- Patient Engagement
- Development of Intellectual Capital - Innovation

Return on Investment (ROI) Analysis
Health Care Delivery System

Economic ROI

Non-Econom

Investment

Personnel Investment

Recruitment

Training

CP Wages

CP Benefits

Support Personnel Wages

Support Personnel Benefits

Operating Investment

Non-Capital Equipment

Supplies

IT Support

Continuing Education

Utilities

Fuel

Vehicle Maintenance

Uniforms

Other Administrative Expenses

Capital Investment

Vehicles

Office Space

System Expense Allocation (May be Excluded if Analysing Incremental ROI)

Payer Savings in ACO or IHP (Foregone Health System Revenue)

Return

Medicaid Fee-For Service Revenue

Grant Revenue

ACO Revenue - Shared Savings or Bonus Payments

Direct Patient Revenue

Other Contracted Revenue - Employer or other buyer arrangements

Capitated Contract Returns over Expected

Quality Incentive Bonuses

Value Based Bonuses

Reduction in Expected Value Based Penalties

on-Economic ROI

Investment

Research & Development

Return

Community Goodwill

Improved Market Perception/Reputation

Larger Demonstrated Community Benefit

Employee Engagement

Patient Engagement

Development of Intellectual Capital - Innovation

Stronger Market Position - Larger Market Share

Return on Investment (ROI) Analysis

Payer

Economic ROI

Investment (Likely incurred by a health care system or EMS provider, but could be paid by Payer)

Personnel Investment

- Recruitment

- Training

- CP Wages

- CP Benefits

- Support Personnel Wages

- Support Personnel Benefits

Operating Investment

- Non-Capital Equipment

- Supplies

- IT Support

- Continuing Education

- Utilities

- Fuel

- Vehicle Maintenance

- Uniforms

- Other Administrative Expenses

Capital Investment

- Vehicles

Office Space

Return

Reduced Expenditures on Beneficiaries

Non-Economic ROI

Investment

Research & Development

Return

Community Goodwill

Improved Market Perception/Reputation

Larger Demonstrated Community Benefit

Customer Engagement

Development of Intellectual Capital - Innovation

Stronger Market Position - Larger Market Share



Community Paramedic Quality Review Form

Patient name: _____ CP provider _____

Incident number: _____ Date of visit _____

Date of referral _____ Response appropriate _____ Date of Chart Audit __9/05/2017

1. Medical provider referral on the chart for every visit? Y / N
2. Patient chrono attached and utilized? Y / N
3. Physician summary attached? Y / N
4. Are all of the MD orders documented in the PCR? Y / N
5. Are all of the patient/client contacts documented in the chart? Y / N
6. Assessments completed and if so documented? Y / N
7. Previous CP visits? Y / N
8. Did the CP follow up on any previous abnormal findings? Y / N/ NA
9. Home health and HIPAA paperwork completed Y / N
10. Is the H&P from the primary care physician included with chart? Y / N
11. Accessed by Cerner? Y / N
12. Did patient receive admission packet/Privacy notice? Y/N
13. Prevented further treatment? Y/N/NA
 - a. ED visit
 - b. Hospital admission
 - c. Office visit
 - d. Ambulance call
 - e. Skilled Nursing Facility
14. Are the following PCR fields completed:

<input type="checkbox"/> Name of CP Responder	<input type="checkbox"/> Patient name
<input type="checkbox"/> Provider Making Referral	<input type="checkbox"/> Date of Call
<input type="checkbox"/> Medical Home/Primary provider	<input type="checkbox"/> Type of Insurance
<input type="checkbox"/> Services Ordered	<input type="checkbox"/> Additional Services Provided
<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Recently Hospitalized?
<input type="checkbox"/> Recommended Referral	<input type="checkbox"/> Race/Ethnicity
<input type="checkbox"/> Language	<input type="checkbox"/> Age/DOB
<input type="checkbox"/> Gender	<input type="checkbox"/> Home Address
<input type="checkbox"/> Mailing Address	

Comments: _____

Audit Completed by Jeri Lu Atkins, MD, Medical Director

MD signature: _____

Reviewed: Marc A. Burdick, Quality Manager

Survey Status: Development iam48 | [My Profile](#) | [Log out](#)

Actions: [Move to production status](#) | [Archive survey](#) | [Download survey as PDF](#)

Survey title: **Community Paramedic Quality of Life Assessment** Original creation date:
01/20/2016
Last response:
09/26/2016 3:34 pm

[My Surveys](#) | [Edit Info](#) | [Design](#) | **Preview** | [Collect Responses](#) | [Admins](#)

[Results](#)

Preview Your Survey

Displayed below is a one-page preview of the survey as it will be viewed by your participants.

Beginning of Survey

Community Paramedic Quality of Life Assessment

Please complete the survey below.

Thank you!

1) Enter patients MRN	<input type="text"/>	* required
2) Please rate your level of mobility around the house. 1 = no problems to 5 = confined to bed	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5	reset value
3) Please rate your ability to care for yourself. 1 = no problems to 5 = cannot dress or bathe myself	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5	reset value
4) Please rate your ability to perform regular activities (e.g. work, housework, family activities, leisure). 1 = no problems to 5 = cannot perform regular activities at all	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5	reset value
5) Please rate your level of pain or discomfort with 1 being no pain or discomfort to 5 being extreme pain or discomfort. 1 = no pain or discomfort to 5 = extreme pain or discomfort	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5	reset value
6) Please rate your level of anxiety or depression. 1 = no anxiety/feeling depressed to 5 = extreme anxiety/depression	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5	

	reset value
<p>7) I am comfortable with knowing how to take my medications.</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>* required</p>	reset value
<p>8) I understand my care plan.</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>* required</p>	reset value
<p>9) I have enough support from my healthcare providers</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>* required</p>	reset value
<p>10) I have an Advanced Directive.</p> <p><input type="radio"/> Yes <input type="radio"/> No</p> <p>* required</p>	reset value
<p>11) Using the scale provided please share how you would rate your overall health (select a radio button on the scale where you think this is today).</p> <p>1 = Worst Imaginable Health State to 10 = Best Imaginable Health State</p> <p><input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10</p> <p>* required</p>	reset value
<p>12) Please rate your overall rating of care received during your Community Paramedic visit.</p> <p>1 = extremely dissatisfied to 5 = very satisfied</p> <p><input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5</p> <p>* required</p>	reset value
<p>13) Please rate the likelihood of recommending our Community Paramedic service to others.</p> <p>1 = Very unlikely to 5 = very likely</p> <p><input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5</p> <p>* required</p>	reset value
<input type="button" value="Submit"/>	

Mobile Integrated Healthcare Program

Measurement Strategy Overview

Aim

A clearly articulated goal statement that describes how much improvement by when and links all the specific outcome measures; what are we trying to accomplish?

Develop a uniform set of measures which leads to the optimum sustainability and utilization of patient centered, mobile resources in the out-of-hospital environment and achieves the Triple Aim® — improve the quality and experience of care; improve the health of populations; and reduce per capita cost.

Measures Definition:

1. 18 Core Measures {"CORE MEASURE" in the description}

- a. Measures that are considered by the measures development team through experience as **essential for program integrity, patient safety and outcome demonstration.**

2. CMMI Big Four Measures (RED)

- a. Measures that have been identified by the CMS Center for Medicare and Medicaid Improvement (CMMI) as the four primary outcome measures for healthcare utilization.

3. MIH Big Four Measures (ORANGE)

- a. Measures that are considered **mandatory** to be reported in order to classify the program as a bona-fide MIH or Community Paramedic program.

4. Top 18 Measures (Highlighted)

- a. The 18 measures identified by the numerous operating MIH/CP programs as **essential, collectable and highest priority to their healthcare partners.**

Notes:

1. All financial calculations are based on the ***national average Medicare payment*** for the intervention described. Providers are encouraged to also determine the ***regional average Medicare payment*** for the interventions described.
2. Value may also be determined by local stakeholders in different ways such as reduced opportunity cost, enhanced availability of resources. Program sponsors should develop local measures to demonstrate this value as well.

Table of Contents

	<u>Page</u>
Structure/Program Design Measures	6
• <u>S1: Executive Sponsorship</u>	6
• <u>S2: Strategic Plan</u>	6
• <u>S3: Healthcare Delivery System Gap Analysis</u>	7
• <u>S4: Community Resource Capacity Assessment</u>	8
• <u>S5: Integration/Program Integrity</u>	8
• <u>S6: Organizational Readiness Assessment – Medical Oversight</u>	9
• <u>S7: Organizational Readiness Assessment - Health Information Technology (HIT)</u>	10
• <u>S8: HIT Integration with Local/Regional Healthcare System</u>	10
• <u>S9: Public & Stakeholder Engagement</u>	11
• <u>S10: Specialized Training and Education</u>	11
• <u>S11: Compliance Plan</u>	11
Outcome Measures for <i>Community Paramedic</i> Program Component	12
• <i>Quality of Care & Patient Safety Metrics</i>	
○ <u>Q1: Primary Care Utilization</u>	12
○ <u>Q2: Medication Inventory</u>	12
○ <u>Q3: Care Plan Developed</u>	12
○ <u>Q4: Provider Protocol Compliance</u>	13
○ <u>Q5: Unplanned Acute Care Utilization (e.g.: emergency ambulance response, urgent ED visit)</u>	13
○ <u>Q6: Adverse Outcomes</u>	13
○ <u>Q7: Community Resource Referral</u>	13
○ <u>Q8: Behavioral Health Services Referral</u>	13
○ <u>Q9: Alternative Case Management Referral</u>	14
• <i>Experience of Care Metrics</i>	
○ <u>E1: Patient Satisfaction</u>	15
○ <u>E2: Patient Quality of Life</u>	15
• <i>Utilization Metrics</i>	
○ <u>U1: Ambulance Transports</u>	16
○ <u>U2: Hospital ED Visits</u>	16
○ <u>U3: All - cause Hospital Admissions</u>	16
○ <u>U4: Unplanned 30-day Hospital Readmissions</u>	16
○ <u>U5: Length of Stay</u>	16

- *Cost of Care Metrics -- Expenditure Savings*
 - **C1: Ambulance Transport Savings (ATS)** 17
 - **C2: Hospital ED Visit Savings (HEDS)** 17
 - **C3: All-cause Hospital Admission Savings (ACHAS)** 17
 - **C4: Unplanned 30-day Hospital Readmission Savings (UHRS)** 18
 - **C5: Unplanned Skilled Nursing (SNF) and Assisted Living Facility (ALF) Savings (USNFS)** 18
 - **C6: Total Expenditure Savings** 18
 - **C7: Total Cost of Care** 19

- *Balancing Metrics*
 - **B1: Provider (EMS/MIH) Satisfaction** 20
 - **B2: Partner Satisfaction** 20
 - **B3: Primary Care Provider (PCP) Use** 20
 - **B4: Specialty Care Provider (SCP) Use** 20
 - **B5: Behavioral Care Provider (BCP) Use** 20
 - **B6: Social Service Provider (SSP) Use** 20
 - **B7: System Capacity -- Emergency Department Use** 20
 - **B8: System Capacity – PCP** 21
 - **B9: System Capacity – SCP** 21
 - **B10: System Capacity – BCP** 21
 - **B11: System Capacity – SSP** 21

Definitions

Measure Categories

Structure: Describes the acquisition of physical materials and development of system infrastructures needed to execute the service (Rand). For example:

- Community Health Needs Assessment
- Community Resource Capacity Assessment
- Executive Sponsorship, Strategic Plan & Program Launch Milestones
- Organizational Readiness Assessment – Health Information Technology Systems
- Organizational Readiness Assessment – Medical Oversight
- Plan for Integration with Healthcare, Social Services and Public Safety Systems

Outcomes: Describes how the system impacts the values of patients, their health and wellbeing (IHI). For example:

Quality of Care Metrics

- Patient Safety
- Care Plan Acceptance and Adherence
- Medical Home
- Medication Inventories

Utilization Metrics

- All-cause Hospital Admissions
- Emergency Department Visits
- Unplanned 30-day Hospital Readmissions

Cost of Care Metrics

- Expenditure Savings by Intervention

Experience of Care Metrics

- Patient Quality of Life
- Patient Satisfaction

Balancing: Describes how changes designed to improve one part of the system are impacting other parts of the system, such as, impacts on other stakeholders such as payers, employees, or community partners (IHI). For example:

- Partner (healthcare, behavior health, public safety, community) satisfaction
- Practitioner (EMS/MIH) satisfaction
- Public and stakeholder engagement
- PCP and other healthcare utilization

Process: Describes the status of fundamental activities associated with the service; describes how the components in the system are performing; describes progress towards improvement goals (Rand/IHI). For example:

- Clinical & Operational Metrics
- Referral & Enrollment Metrics
- Volume of Contacts, Visits, Transports, Readmissions

Definitions: Throughout the document, hyperlinks for certain defined terms are included.

Structure/Program Design Measures

Describes the development of system infrastructures and the acquisition of physical materials necessary to successfully execute the program

Name	Description of Goal	Components	Scoring	Evidence-base, Source of Data
Executive Sponsorship	<p>S1: Program has Executive Level commitment and the program manager reports directly to the Executive leadership of the organization. {CORE MEASURE}</p>	<p>The community paramedicine program plan clearly identifies organizational executive level commitment for the human, financial, capital and equipment necessary to develop, implement, and manage the community paramedicine program both clinically and administratively.</p>	<p>0. There is no evidence of organizational executive level commitment</p> <p>1. There is some evidence of limited commitment for the program.</p> <p>2. There is evidence of full commitment for the program.</p>	<p>Documents submitted by agency demonstrating this commitment such as approved budgets, organizational chart and job descriptions</p>
Strategic Plan	<p>S2: The program has an Executive Level approved strategic plan. {CORE MEASURE}</p>	<p>The strategic plan should be based on the knowledge of improvement science and rapid cycle testing, and include the key components of a Driver Diagram, specific measurement strategies, implementation milestones, a communication plan that includes engagement with local and regional stakeholders and a Financial Sustainability Plan.</p>	<p>0. No evidence of a strategic plan.</p> <p>1. A written strategic plan, but it lacks key components.</p> <p>2. A written strategic plan that includes all key components.</p>	<p>Institute for Healthcare Improvement</p>

Name	Description of Goal	Components	Scoring	Evidence-base, Source of Data
Healthcare Delivery System Gap Analysis	S3: Program is designed to serve unmet needs in the local community. {CORE MEASURE}	<p>There is a description of illnesses and/or injuries within the community paramedicine service area including the distribution by geographic area, high-risk populations (i.e.: high utilizer populations, populations with high prevalence of chronic diseases, etc.), using payer, provider, public health, public safety and other data sources.</p> <p>There is a description of the process and methods used to conduct the HDSGA; describe community input received.</p>	<ol style="list-style-type: none"> 0. There is no written description of illness and/or injuries within the community paramedicine service area. 1. One or more target population-based data sources to describe illness and injury within the target population, but healthcare system utilization data sources are not used. 2. One or more target population-based data sources and one or more healthcare system utilization data sources are used to describe illness and injury prevalence and healthcare system utilization within the service area. 	Adapted from HRSA Community Paramedic Evaluation Tool

Name	Description of Goal	Components	Scoring	Evidence-base, Source of Data
Community Resource Capacity Assessment	S4: Program is designed to address gaps in resource capacity.	The community paramedicine program has completed a comprehensive inventory that identifies the availability and distribution of current capabilities and resources from a variety of partners and organizations throughout the community.	<ol style="list-style-type: none"> 0. There is no community-wide resource assessment. 1. A resource assessment has been completed that documents the resources available to help meet the clinical needs of patients that may be enrolled in the community paramedicine program. 2. A community-wide resource assessment has been completed that documents the 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 program. 	Adapted from HRSA Community Paramedic Evaluation Tool
Integration/Program Integrity	S5: Program integrates with external regional healthcare system stakeholders	There has been an initial assessment (and periodic reassessment) of overall program effectiveness completed by an external agency (i.e.: CMS Quality Improvement Network or external stakeholder group comprised of healthcare, payer, social service and patient representatives).	<ol style="list-style-type: none"> 0. No external examination of the community paramedicine program overall or individual components has occurred. 1. An outside group of stakeholders has conducted a formal assessment and has made specific recommendations to the program. 2. Independent external reassessment occurs regularly, at least every two years. 	Adapted from HRSA Community Paramedic Evaluation Tool

Name	Description of Goal	Components	Scoring	Evidence-base, Source of Data
Organizational Readiness Assessment – Medical Oversight	S6: Organization is committed to strong medical oversight, effective clinical quality improvement, comprehensive education and continuing education program.	The community paramedicine program medical director has the authority to adopt protocols, implement a performance improvement system, ensure appropriate practice of community paramedicine providers, and generally ensure medical appropriateness of the community paramedicine program based on regulatory agency scope of practice and accepted standards of medical care.	<ol style="list-style-type: none"> 0. There is no community paramedicine program medical director. 1. There is a community paramedicine program medical director with a written job description; however, the individual has no specific authority or time allocated for those tasks. 2. There is a community paramedicine program medical director with a written job description. The community program medical director has adopted protocols, implemented a performance improvement program, and is generally taking steps to improve the medical appropriateness of the community paramedicine program. 	Adapted from HRSA Community Paramedic Evaluation Tool NAEMSP Position Paper on MIH/CP program development

Name	Description of Goal	Components	Scoring	Evidence-base, Source of Data
Organizational Readiness Assessment - Health Information Technology (HIT)	S7: Organization has advanced health information technology systems and infrastructure.	The community paramedicine program has a unique medical record for each enrolled patient; and collects and uses patient data as well as provider data to assess system performance and to improve quality of care.	<ol style="list-style-type: none"> 0. There is no patient centric medical record of CP interventions. 1. Patient centric medical records are used manually but are not used to assess system performance or quality of care. 2. Patient centric medical records are collected electronically and are used to assess both system performance and to improve quality of care across the program. 	Adapted from HRSA Community Paramedic Evaluation Tool
HIT Integration with Local/Regional Healthcare System	S8: Organization has advanced health information technology systems and infrastructure.	The community paramedicine HIT system is integrated with the local healthcare providers to facilitate access to patient records by healthcare system participants.	<ol style="list-style-type: none"> 0. There is no exchange of patient data with other healthcare providers. 1. CP medical records and data are pushed to healthcare providers or a health information exchange or its equivalent. 2. There is bi-directional exchange of the electronic medical record and data for each patient/client contact that can be accessed by primary care providers, case managers, social service agencies and/or payers. 	Adapted from HRSA Community Paramedic Evaluation Tool

Name	Description of Goal	Components	Scoring	Evidence-base, Source of Data
Public & Stakeholder Engagement	S9: Care Coordination Advisory Committee	Community paramedicine program, in concert with relevant stakeholders meets regularly and advises the program on strategies for improving care coordination.	<ul style="list-style-type: none"> 0. There is no care coordination advisory committee. 1. There is evidence of engagement with relevant stakeholders. 2. There is an established care coordination advisory committee and all key stakeholders are represented. 	Adapted from HRSA Community Paramedic Evaluation Tool
Specialized Training & Education	S10: Specialized original and continuing education for community paramedic practitioners	A specialized educational program has been used to provide foundational knowledge for community paramedic practitioners based on a nationally recognized or state approved curriculum.	<ul style="list-style-type: none"> 0. There is no specialized education offered. 1. There is specialized education offered, but it lacks key elements of instruction. 2. There is specialized education offered meeting or exceeding a nationally recognized or state approved curriculum. 	North Central EMS Institute Community Paramedic Curriculum or equivalent.
Compliance with State and Federal Regulations	S11: Compliance Plan { CORE MEASURE }	The community paramedicine program has a plan in place which assures compliance with all applicable laws and regulations and which prevents waste, fraud, abuse.	<ul style="list-style-type: none"> 0. No evidence of a compliance plan. 1. A written compliance plan, but it lacks key components. 2. A written compliance plan that includes all key components. 	Centers for Medicare and Medicaid Services

Outcome Measures for Community Paramedic Program Component

Describes how the system impacts the values of patients, their health and well-being

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
Quality of Care & Patient Safety Metrics	Q1: Primary Care Utilization { CORE MEASURE }	Increase the number and percent of patients utilizing a Primary Care Provider (if none upon enrollment)	Number of Enrolled Patients with an established PCP relationship upon graduation	Number of enrolled patients without an established PCP relationship upon enrollment	Value 1 Value 1/Value 2	Agency records
	Q2: Medication Inventory	Increase the number and percent of medication inventories conducted with issues identified and communicated to PCP	Number of medication inventories with issues identified and communicated to PCP	Number of medication inventories completed	Value 1 Value 1/Value 2	Agency records
	Q3.1: Care Plan Developed { CORE MEASURE }	Increase the number and percent of patients who have an identified and documented plan of care with outcome goals established by a physician and facilitated by the CP	Number of patients with a plan of care communicated by the patient's PCP	All enrolled patients	Value 1 Value 1/Value 2	Agency records
	Q3.2: Care Plan Developed { CORE MEASURE }	Increase the number and percent of patients who have an identified and documented plan of care with outcome goals established by the patient's PCP and facilitated by the CP	Number of patients with a plan of care communicated by the patient's PCP	All enrolled patients	Value 1 Value 1/Value 2	Agency records

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
	Q4: Provider Protocol Compliance {CORE MEASURE}	Eliminate plan of care deviations without specific medical direction supporting the deviation	Number of plan of care deviations without medical direction support	All patient encounters/interventions	Value 1 Value 1/Value 2	Agency records
	Q5: Unplanned Acute Care Utilization (e.g.: emergency ambulance response, urgent ED visit)	Minimize rate of patients who require unplanned acute care related to the CP care plan within 24 hours after a CP intervention	Number of patients who require unplanned acute care related to the CP care plan within 24 hours after a CP intervention	All CP visits in which a referral to Acute Care was NOT REQUIRED	Value 1/Value 2	Agency records
	Q6: Adverse Outcomes {CORE MEASURE}	Minimize adverse effects (harmful or undesired effects) resulting from a medication or other treatment related to CP intervention within 24 hours of the CP intervention	Number of deaths from a cause related to CP intervention	All patient encounters/interventions	Value 1/ Value 2	Agency records
Number of Critical Care Admissions related to CP intervention			All patient encounters/interventions			
	Q7: Community Resource Referral	Increase portion of patients referred to community resources for reconciliation of immediate social, transportation and environmental hazards and risks	Number of referrals to community resources (3 referrals for 1 patient = 3 referrals)	Number of enrolled patients with an identified need	Value 1/ Value 2	Agency records

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
	Q8: Behavioral Health Services Referral	Increase portion of patients referred to a behavioral health professional for behavioral health intervention	Number of patients with an established therapeutic relationship with behavioral health resources	Number of enrolled patients with an identified need	Value 1/ Value 2	Agency records
	Q9: Case Management Referral	Increase portion of patients referred to case management services	Number of patients with an established therapeutic relationship to case management resources	Number of enrolled patients with an identified need	Value 1/ Value 2	Agency records

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
Experience of Care Metrics	E1: Patient Satisfaction {CORE MEASURE}	Optimize patient satisfaction scores by intervention.	To be determined based on tools developed	To be determined based on tools developed		Recommend an externally administered and nationally adopted tool, such as, HCAPHS; Home Healthcare CAPHS (HHCAPHS)
	E2: Patient Quality of Life	Improve patient self-reported quality of life scores.	To be determined based on tools developed	To be determined based on tools developed		Recommended tools (EuroQol EQ-5D-5L, CDC HRQoL, University of Nevada-Reno)

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Notes
Utilization Metrics	U1: Ambulance Transports { CORE MEASURE }	Reduce rate of unplanned ambulance transports to an ED by <i>enrolled patients</i>	Number of <i>unplanned</i> ambulance transports up to 12 months post-graduation	Number of <i>unplanned</i> ambulance transports up to 12 months pre- Enrollment	(Value 1-Value 2)/Value 2	Monthly run chart reporting and/or pre-post intervention comparison
	U2: Hospital ED Visits { CORE MEASURE }	Reduce rate of ED visits by <i>enrolled patients</i> by intervention	ED visits up to 12 months post-graduation	ED visits up to 12 months pre-enrollment	(Value 1-Value 2)/Value 2	Monthly run chart reporting and/or pre-post intervention comparison
			OR Number of ED Visits avoided in CP intervention patient		Value 1	
	U2.1: Emergency Department Capacity	Increase number of hours of ED bed utilization avoided by CP patients during measurement period	Number of ED visits post enrollment * average Door to Disposition time for all ED patients	Number of ED visits pre enrollment * average Door to Disposition time or all ED patients	Value 1-Value 2	Monthly run chart reporting and/or pre-post intervention comparison
	U3: All - cause Hospital Admissions { CORE MEASURE }	Reduce rate of all-cause hospital admissions by <i>enrolled patients</i> by intervention	Number of hospital admissions up to 12 months post-graduation	Number of hospital admissions up to 12 months pre-enrollment	(Value 1-Value 2)/Value 2	Monthly run chart reporting and/or pre-post intervention comparison
	U4: Unplanned 30-day Hospital Readmissions { CORE MEASURE }	Reduce rate of all-cause, unplanned, 30-day hospital readmissions by <i>enrolled patients</i> by intervention	Number of actual 30-day readmissions	Number of anticipated 30-day readmissions	(Value 1-Value 2)/Value 2	Monthly run chart reporting and/or pre-post intervention comparison
	U5: Length of Stay	Reduce Average Length of Stay by enrolled patients by DRG	ALOS by DRG for enrolled patients at end of implementation year X	ALOS by DRG for patients NOT enrolled at the end of implementation year X	(Value 1-Value 2)/Value 2	Monthly run chart reporting and/or pre-post intervention comparison

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
Cost of Care Metrics -- Expenditure Savings	C1: Ambulance Transport Savings (ATS) {CORE MEASURE}	Reduce Expenditures for unplanned ambulance transports to an ED <i>pre and post enrollment or per event</i>	Ambulance transport utilization change in measure period X average payment per transport for enrolled patients MINUS Expenditure per CP Patient Contact	Number of patients enrolled in the CP program	Value 1 / Value 2	Monthly run chart reporting and/or pre-post intervention comparison CMS Public Use Files (PUF) for ambulance supplier expenditures or locally derived number
	C2: Hospital ED Visit Savings (HEDS) {CORE MEASURE}	Reduce expenditures for ED visits <i>pre and post enrollment or per event</i>	ED utilization change in measure period X average payment per ED visit for enrolled patients MINUS Expenditure per CP patient contact	Number of patients enrolled in the CP program	Value 1/ Value 2	Monthly run chart reporting and/or pre-post intervention comparison Medical Expenditure Panel Survey (MEPS), or individually derived payer data
	C3: All-cause Hospital Admission Savings (ACHAS) {CORE MEASURE}	Reduce expenditures for All-Cause Hospital Admissions <i>pre and post enrollment or per event</i>	Hospital admission change in measure period X average payment per admission for enrolled patients MINUS Expenditure per CP patient contact	Number of patients enrolled in the CP program	Value 1/ Value 2	Monthly run chart reporting and/or pre-post intervention comparison Medical Expenditure Panel Survey (MEPS), or individually derived payer data

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
	C4: Unplanned 30-day Hospital Readmission Savings (UHRS) {CORE MEASURE}	Reduce expenditures for all-cause, unplanned, 30-day hospital readmissions <i>pre and post enrollment or per event</i>	Hospital readmission change in measure period X average payment per readmission for enrolled patients	Number of patients enrolled in the CP program	Value 1/ Value 2	Monthly run chart reporting and/or pre-post intervention comparison Medical Expenditure Panel Survey (MEPS), or individually derived payer data
	C5: Unplanned Skilled Nursing (SNF) and Assisted Living Facility (ALF) Savings (USNFS)	Reduce expenditures for all-cause, unplanned, skilled nursing and/or assisted living facility admissions pre and post enrollment or per event	SNF and/or ALF admissions change in measure period X average payment per admission for enrolled patients	Number of patients enrolled in the CP program	Value 1/ Value 2	Monthly run chart reporting and/or pre-post intervention comparison Medical Expenditure Panel Survey (MEPS), or individually derived payer data
	C6: Total Expenditure Savings {CORE MEASURE}	Total expenditure savings for all CP interventions	Calculated savings for each enrollee (ATS+HEDS + (ACHAS or UHRS)+USNFS)) MINUS the Expenditure of the CP interventions for intervention per enrollee, including alternative sources of care Expenditures		Sum of Value 1	Monthly run chart reporting and/or pre-post intervention comparison

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
	C7: Total Cost of Care	Reduce total healthcare expenditures for enrolled patients	Total cost of care for enrolled patients for 12 months post enrollment MINUS total cost of care for enrolled patients pre-enrollment			Payer Derived

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
Balancing Metrics	B1: Practitioner (EMS/MIH) Satisfaction	Optimize practitioner satisfaction scores	To be determined based on tools developed			Recommend externally administered
	B2: Partner Satisfaction	Optimize partner (healthcare, behavior health, public safety, community) satisfaction scores	To be determined based on tools developed			Recommend externally administered
	B3: Primary Care Provider (PCP) Use	Optimize Number of PCP visits resulting from program referrals during enrollment	Number of PCP visits during enrollment		Value 1	Network provider or patient reported
	B4: Specialty Care Provider (SCP) Use	Optimize number of SCP visits resulting from program referrals during enrollment	Number of SCP visits during enrollment		Value 1	Network provider or patient reported
	B5: Behavioral Care Provider (BCP) Use	Optimize number of BCP visits resulting from program referrals during enrollment	Number of BCP visits during enrollment		Value 1	Network provider or patient reported
	B6: Social Service Provider (SSP) Use	Optimize number of SSP visits resulting from program referrals during enrollment	Number of SSP visits during enrollment		Value 1	Network provider or patient reported
	B7: Emergency Department Capacity	Decrease number of hours of ED bed utilization by CP patients during measurement period	Number of ED visits post enrollment * average Door to Disposition time for all ED patients	Number of ED visits pre enrollment * average Door to Disposition time or all ED patients	Value 1-Value 2	Monthly run chart reporting and/or pre-post intervention comparison

Domain	Name	Description of Goal	Value 1	Value 2	Formula	Evidence-base, Source of Data
	B8: System Capacity - PCP	Number and percent of patients unable to receive PCP services that they would otherwise be eligible to receive as a result of lack of PCP system capacity	Number of patients referred to PCP services that were unable to receive PCP services due to lack of PCP capacity	Number of patients referred to PCP services	Value 1 Value 1/Value 2	Network provider or patient reported
	B9: System Capacity - SCP	Number and percent of patients unable to receive SCP services that they would otherwise be eligible to receive as a result of lack of SPC system capacity	Number of patients referred to SCP services that were unable to receive SPC services due to lack of SPC capacity	Number of patients referred to SCP services	Value 1 Value 1/Value 2	Network provider or patient reported
	B10: System Capacity - BCP	Number and percent of patients unable to receive BCP services that they would otherwise be eligible to receive as a result of lack of BCP system capacity	Number of patients referred to BCP services that were unable to receive BCP services due to lack of BCP capacity	Number of patients referred to BCP services	Value 1 Value 1/Value 2	Network provider or patient reported
	B11: System Capacity - SSP	Number and percent of patients unable to receive SSP services that they would otherwise be eligible to receive as a result of lack of SSP system capacity	Number of patients referred to SSP services that were unable to receive SSP services due to lack of SSP capacity	Number of patients referred to SSP services	Value 1 Value 1/Value 2	Network provider or patient reported

Definitions

Specific Metric Definitions:

Expenditure: The amount **PAID** for the referenced service. Expenditures should generally be based on the national and regional amounts paid by Medicare for the covered services provided.

Examples:

Service	Cost to Provide the Service by the Provider	Amount Charged (billed) by the Provider	Average Amount Paid by Medicare
Ambulance Transport	\$350	\$1,500	\$420
ED Visit	\$500	\$2,000	\$969
PCP Office Visit	\$85	\$199	\$218

National CMS Expenditure by Service Type (note: it is preferable to use local or regional data if available, if not, these sources can be surrogate data if needed):

Service	Average Expenditure	Source
Emergency Ambulance Transport	\$419	Medicare Tables from CY 2012 as published
ED Visit	\$969	http://www.cdc.gov/nchs/data/hus/hus12.pdf
PCP Office Visit	\$218	http://meps.ahrq.gov/data_files/publications/st381/stat381.pdf
Hospital Admission	\$10,500	http://www.hcup-us.ahrq.gov/reports/projections/2013-01.pdf

Triple Aim

- Improve the quality and experience of care
- Improve the health of populations
- Reduce per capita cost

Driver Diagram: A Driver Diagram is a strong one-page conceptual model which describes the projects' theory of change and action. It is a central organizing element of the operations/implementation plan and includes the aim of the project and its goals, measures, primary drivers and secondary drivers. The aim statement describes what is to be accomplished, by how much, by when and where?

- Aim – A clearly articulated goal statement that describes how much improvement by when and links all the specific measures. What are we trying to accomplish? CMMI/IHI.
- Primary Drivers – System components that contribute directly to achieving the aim; each primary driver is linked to clearly defined outcome measure(s). CMMI.
- Secondary Drivers – Actions necessary to achieve the primary driver; each secondary driver is linked to clearly defined process measure(s). CMMI.

General Definitions

- **Adverse Outcome:** Death, temporary and/or permanent disability requiring intervention.
- **All Cause Hospital Admission:** Admission to an acute care hospital for any admission DRG.
- **Average Length of Stay:** The average duration, measured in days, of an in-patient admission to an acute care, long term care, or skilled nursing facility
- **Care Plan:** A written plan that addresses the medical and psychosocial needs of an enrolled patient that has been agreed to by the patient and the patient's primary care provider.
- **Case Management Services:** Care coordination activities provided by another social service agency, health insurance payer, or other organization.
- **Compliance Plan:** A Compliance Plan clearly articulates policies, procedures and processes to assure compliance with all applicable laws and regulations associated with the community paramedicine program, including; prevention, detection and correction; conflict of interest policies; and mechanisms for identifying and addressing noncompliance.
- **Core Measure:** Required measurement for reporting on MIH-CP services.
- **Critical Care Unit Admissions or Deaths:** Admission to critical care unit within 48 hours of CP intervention; unexpected (non-hospice) patient death within 48 hours of CP visit.
- **Desirable Metric:** Optional measurement.
- **Door to Disposition Time:** "Door" time is defined according to the EMTALA and the AHA STEMI Guidelines: "The time at which the ambulance arrives at the hospital." **Disposition** time means the time at which the patient is admitted to the hospital as an inpatient or observation patient; or a patient is designated for observation within a Clinical Decision area of the ED, or is discharged from the ED.
- **Enrolled Patient:** A patient who is enrolled with the EMS/MIH program through either; 1) a 9-1-1 or 10-digit call; 2) a formal referral and enrollment process, or 3) contact by a provider within the EMS system with additional training on handling special patient populations.
- **Evaluation:** determination of merit using standard criteria.
- **Executive Level:** The most senior leadership of the organization. For governmental agencies, this should be the Chief of the Department, City/County Manager, City/County Commission, or other similar leadership. For private agencies, this would be the owner, CEO, President, Executive Director, or other similar leadership.
- **Expenditure per CP Patient Contact:** The average payment received by the agency calculated at a per patient contact rate. For example, if the agency is receiving payments on a per patient contact basis of \$75, then the average expenditure per patient contact is \$75. If the agency is getting an enrollment fee of \$1,200 and the average number of patient contacts per enrollment is 9, then the expenditure per patient contact is $\$1,200 / 9 = \133.34 .
- **Financial Sustainability Plan:** a document that describes the expected revenue and/or the economic model used to sustain the program.
- **Guideline:** a statement, policy or procedure to determine course of action.

- Hotspotter/ High Utilizer: Any patient utilizing EMS or ED services 12 times in a 12 month period, or as defined by local program goals.
- Measure: dimension, quantity or capacity compared to a standard.
- Medication Inventory: The process of creating the most accurate list possible of all medications a patient is taking — including drug name, dosage, frequency, and route — and comparing that list against the physician’s admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patient at all transition points within the hospital.
- Metric: a standard of measurement.
- Payer Derived: Measure that must be generated by a payer from their database of expenditures for a member patient.
- Pre and Post Enrollment: The beginning date and ending date of an enrolled patient.
- Primary Care Provider: The licensed care provider who is primarily responsible for the medical care of the patient. Generally, this provider develops the patient’s care plan, including the assessments and interventions to be completed by a community paramedic. It could be a physician, or an established Patient Centered Medical Home such as a community clinic or Federally Qualified Health Center.
- Repatriation: Returning a person to their original intended destination, such as an emergency department, following an intervention
- Social & Environmental Hazards and Risks: include trip/fall hazards, transportation, electricity, food, etc.
- Standard: criteria as basis for making a judgment.
- Total Expenditure Savings: The calculated savings based on the number of avoided events (i.e.: ambulance transports, ED visits, admissions) for all enrolled patients in the CP intervention.
- Unplanned: Any service that is not part of a patient’s plan of care.

APPENDIX 12

EVALUATE THE PROGRAM

12.1 – SAMPLE PATIENT SURVEY

Survey Status: Development

iam48 | [My Profile](#) | [Log out](#)

Actions: [Move to production status](#) | [Archive survey](#) | [Download survey as PDF](#)

Survey title:

Community Paramedic Quality of Life Assessment

Original creation date:
01/20/2016

Last response:
09/26/2016 3:34 pm

[My Surveys](#)

[Edit Info](#)

[Design](#)

Preview

[Collect Responses](#)

[Admins](#)

[Results](#)

Preview Your Survey

Displayed below is a one-page preview of the survey as it will be viewed by your participants.

Beginning of Survey

Community Paramedic Quality of Life Assessment

Please complete the survey below.

Thank you!

1)	Enter patients MRN	<input type="text"/>
		* required
2)	Please rate your level of mobility around the house. 1 = no problems to 5 = confined to bed	
	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5	reset value
	* required	
3)	Please rate your ability to care for yourself. 1 = no problems to 5 = cannot dress or bathe myself	
	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5	reset value
	* required	
4)	Please rate your ability to perform regular activities (e.g. work, housework, family activities, leisure). 1 = no problems to 5 = cannot perform regular activities at all	
	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5	reset value
	* required	
5)	Please rate your level of pain or discomfort with 1 being no pain or discomfort to 5 being extreme pain or discomfort. 1 = no pain or discomfort to 5 = extreme pain or discomfort	
	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5	reset value
	* required	
6)	Please rate your level of anxiety or depression. 1 = no anxiety/feeling depressed to 5 = extreme anxiety/depression	
	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5	

	reset value
7) I am comfortable with knowing how to take my medications. <input type="radio"/> Yes <input type="radio"/> No * required	reset value
8) I understand my care plan. <input type="radio"/> Yes <input type="radio"/> No * required	reset value
9) I have enough support from my healthcare providers <input type="radio"/> Yes <input type="radio"/> No * required	reset value
10) I have an Advanced Directive. <input type="radio"/> Yes <input type="radio"/> No * required	reset value
11) Using the scale provided please share how you would rate your overall health (select a radio button on the scale where you think this is today). 1 = Worst Imaginable Health State to 10 = Best Imaginable Health State <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 <input type="radio"/> 10 * required	reset value
12) Please rate your overall rating of care received during your Community Paramedic visit. 1 = extremely dissatisfied to 5 = very satisfied <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 * required	reset value
13) Please rate the likelihood of recommending our Community Paramedic service to others. 1 = Very unlikely to 5 = very likely <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 * required	reset value
<input type="button" value="Submit"/>	