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VISION STATEMENT ON MOBILE INTEGRATED HEALTHCARE (MIH)

Mobile Integrated Healthcare (MIH) is the provision of healthcare using patient-centered, mobile resources in the out-of-hospital environment. It may include, but is not limited to, services such as providing telephone advice to 9-1-1 callers instead of resource dispatch; providing community paramedicine care, 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.

Key components of MIH programs include:

- Fully integrated – a vital component of the existing healthcare system, with efficient bidirectional sharing of patient health information.
- Collaborative – predicated on meeting a defined need in a local community articulated by local stakeholders and supported by formal community health needs assessments.
- Supplemental – enhancing existing healthcare systems or resources, and filling the resource gaps within local community.
- Data driven – data collected and analyzed to develop evidence-based performance measures, research and benchmarking opportunities.
- Patient-centered – incorporating a holistic approach focused on the improvement of patient outcomes.
- Recognized as the multidisciplinary practice of medicine – overseen by engaged physicians and other practitioners involved in the MIH program, as well as the patient’s primary care network/patient-centered medical home, using telemedicine technology when appropriate and feasible.
- Team based – integrating multiple providers, both clinical and non-clinical, in meeting the holistic needs of patients who are either enrolled in or referred to MIH programs.
- Educationally appropriate – including more specialized education of community paramedicine and other MIH providers, with the approval of regulators or local stakeholders.
- Consistent with the Institute for Healthcare Improvement’s IHI Triple Aim philosophy of improving the patient experience of care; improving the populations; and reducing the per capita cost of healthcare.
- Financially sustainable – including proactive discussion and financial planning with federal payers, health systems, Accountable Care Organizations, Managed Care Organizations, Physician Hospital Organizations, legislatures, and other stakeholders to establish MIH programs and component services as an element of the overall (IHI) Triple Aim approach.

EMS APPLICATION for a Mobile Integrated Healthcare Pilot Program

EMS System name:

EMS MD name:

EMSS Coordinator:

EMS MD signature

EMSS Coord signature:

EMS MD e-mail address:

EMSS Coord e-mail address:

Needs assessment (What gap(s) are you attempting to solve or resolve with the proposed plan? Please be specific)

What outcome points from the Institute of Healthcare Improvement Triple Aim Initiative to optimize health system performance will this proposal attempt to achieve? (check all that apply)

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care

Communities and agencies involved/consulted as part of the planning/implementation.(Mobile Integrated Healthcare proposal should include additional communities and agencies that will be part of the program)

Concept design - Complete the sections below that apply to your proposal

Suggested models for Illinois: Provide the right care, in the right place, at the right time and the right cost

Select the model(s) that most closely describe(s) your proposed plan(s):

- Preventing readmissions to EDs/hospitals for patients with diseases such as pulmonary edema, community acquired pneumonia, asthma, diabetes or those that would be equally or better served at an alternative care deliver site. This could include safety checks; follow-up calls/visits for previous EMS patients; working with home health agencies to provide follow-up visits, transporting patients to alternate care delivery sites or not transporting at all following an assessment, etc...
- Enhancing palliative care/working with hospice programs to optimize patient wishes with respect to end of life care
- Working with hospitals to provide appropriate dispensation for observation admissions to seek alternative care models based on implementation of the 2 midnight rules
- Illness/injury prevention programs: Including but not limited to providing selective immunizations and community education.

Describe your proposed program plan

What relevant laws, rules, regulations, or guidelines may apply or support your proposal?

Mobile Integrated Healthcare Proposal

Describe how this program will improve patient care in any or all of the following ways:

Individuals and families – Enable individuals and families to better manage their health

- Establish partnerships among individuals, families and caregivers for medically and socially complex patients that will identify a family member or friend who will be supported and developed to coordinate services among multiple providers of care
- Customize care at the level of the individual (patient-centric care).

Redesign of care models – Collaborate with an integrated team that can provide necessary medical and health-related services to the targeted population.

- Build an access platform for maximum flexibility to provide customized health care for the needs of patients, families and providers
- Foster collaboration and coordination with other specialties, hospitals and community services related to population health

Prevention and Health Promotion – Promote and link program participants to education resources that support health promotion, disease prevention and illness/injury management.

- Work with the community to advocate and provide incentives for healthy lifestyles and illness/injury prevention
- Develop partnerships, use key stakeholder resources and align policies to provide community-based support for those who wish to make health-related behavior changes or promote illness/injury prevention.

System Integration – Data is used from health risk assessments, medical history and prior resource utilization to select the targeted participants.

- * Partner, not compete, with existing care delivery models and/or services
- * Match capacity and demand for healthcare and social services across suppliers
- * Insure that strategic planning with all communities of interest are informed by the needs of the population
- * Set and execute strategic initiatives related to reducing inequitable variation in outcomes or undesirable variation in clinical practice

Per capita cost reductions (Hospital and ED utilization rates; EMS response reductions) - Reduce cost by developing cooperative relationships with physician groups and other healthcare organizations and reward healthcare providers, hospitals, and health care systems for their contributions to producing better health for the population.

Orient the patient journey over time to achieve the best feasible outcomes at the most value-driven cost.

Funding:

Initial capitalization and sustainability. How will the plan create a sustainable governance and financial structure?

Metrics

How will you measure achievement of the program goals and objectives?

Education: What additional education will need to be created / provided to EMS practitioners to function within the new care delivery model?

If other than the System EMS MD, who will be providing consultative **medical oversight** to allied health personnel, including EMTs and paramedics that are part of the care delivery model?

List name, credentials and contact information:

Signatures communities of interest/participants:

Print name	Signature	Affiliation
Print name	Signature	Affiliation
Print name	Signature	Affiliation
Print name	Signature	Affiliation
Print name	Signature	Affiliation
Print name	Signature	Affiliation
Print name	Signature	Affiliation
Print name	Signature	Affiliation
Print name	Signature	Affiliation
Print name	Signature	Affiliation

FORWARD TO IDPH Regional EMS Coordinator for comments:

- Application complete; forward to IDPH (Springfield) for plan amendment approval
- Application or explanations incomplete; return to EMS System for additional documentation/substantiation. See comments below:

IDPH Regional EMS Coordinator

Date

MOBILE INTEGRATED HEALTHCARE

Community Assessment Tool

I. Community Needs

- a. Public Sector Private Sector
- b. What is the community healthcare issue or gap that will be addressed? Please state your intended goal(s).
 - Improving the patient experience of care (including quality and satisfaction)
 - Improving the health of populations
 - Reducing the per capita cost of health care
- c. What measurement was used to determine that this was an issue or that healthcare in the community could be improved? Please list:
 - i. Data review or patient care report review

 - ii. Other measurement or directive/request from primary care, hospital etc.

II. Resources/Inputs

- a. Please describe the resources you plan on dedicating to the project?
 - i. Vehicles, personnel, hours etc.

- b. Community Resource Referral List (i.e. Social Services, Primary Care etc.)

III. Evaluation of Outcomes

(To be reported quarterly to IDPH/Resource Hospital)

- a. What are the results? How will you measure?
 - i. What mechanism was used to measure outcomes?
 - 1. Data or Report review
 - a. Re-admissions
 - b. ED visit decreases
 - c. Decrease/Increase of the frequent caller
 - 2. Patient satisfaction surveys of patient experience
 - 3. Further integration/networking opportunities across the healthcare continuum for EMS

**Primary Care Provider Collaborative Agreement
Mobile Integrated Healthcare (MIH)**

This form is to be completed by primary care providers who anticipate enrolling patients in the MIH Program provided by participating Emergency Medical Services (EMS) providers in their area. Participation is voluntary for primary care providers, their patients and EMS providers. This model is designed to assist primary care providers with the assessment of patients with specific care plans that are not able to receive traditional home health care services. This model is not designed to replace traditional home health care services.

Patients participating in the program may be referred by their local EMS agency based on EMS call patterns, or by their outpatient primary care provider or inpatient hospital and primary care provider.

Enrolled primary care providers agree to develop an outpatient care plan, communicate what assessments tool(s) are to be utilized, and agree to receive information regarding their participating patients.

Once enrolled, a primary care provider may refer patients to the program. The primary care provider agrees that they are acting within this collaborative agreement with the EMS Medical Director who oversees the care delivered by EMS providers. The primary care provider will be able to receive the patient assessment data, and make recommendations to the patient directly if appropriate. These recommendations may include care plan adjustments, or recommendations to be re-evaluated.

The EMS providers will function using a pre-approved algorithm selected for the patient. Routine visit data without unexpected findings will be forwarded to the primary care provider's office. Significant changes in patient status may need to be relayed to the primary care provider immediately, the primary care provider agrees to receive the information and intervene if necessary. Changes in the patient's medications or care plan would be communicated to the patient or their authorized caregiver directly. **The EMS provider will not be authorized to take medical orders from the primary care provider.** The EMS provider functions using a pre-approved algorithm.

If the EMS provider performing the patient assessment feels that there is an emergency situation, the EMS Provider will begin treatment within their scope of practice and resources available, activate EMS/911, and implement emergency care protocols. This care will fall under the EMS Medical Director, and will most often result in transport of the patient to the hospital by protocol. Enrolling primary care providers must complete the following:

Name and credentials of primary care provider collaborating with the EMS Medical Director

Signature of primary care provider

Contact information:

Office addresses and phone numbers: _____

Pager number or answering service: _____

Hospital Affiliations: _____

MOBILE INTEGRATED HEALTHCARE
Post Discharge and Re-admission Prevention Program
Adult Patient Enrollment Form

To be completed by Initiating Primary Care Provider/Designee

Patient's Name: _____

Date of Implementation: _____

Primary Care Provider: _____

EMS Medical Director: _____

Implement for all adult patients enrolled in program	
<input checked="" type="checkbox"/>	Residence Safety Assessment
Primary Care Provider to indicate which of the following guidelines are to be implemented for the above enrolled patient.	
<input type="checkbox"/>	Asthma Assessment Guidelines
<input type="checkbox"/>	Diabetic Assessment Guidelines
<input type="checkbox"/>	Heart Failure Assessment Guidelines
<input type="checkbox"/>	Orthopedic Assessment Guidelines
<input type="checkbox"/>	Pneumonia Assessment Guidelines
<input type="checkbox"/>	Post MI Assessment Guidelines

Routine visit data without unexpected findings will be forwarded to the practitioner's office. Significant changes in patient status may need to be relayed to the primary care provider immediately, the primary care provider agrees to receive the information and intervene if necessary. Changes in the patient's medications or care plan would be communicated to the patient and/or their authorized caregiver directly. **The EMS provider will not be authorized to take medical orders from the primary care provider.**

Please Attach the Following Patient Documents	
<input type="checkbox"/>	Hospital Discharge Summary / Discharge Plan
<input type="checkbox"/>	Discharge Medication List
<input type="checkbox"/>	Other: Authorized Caregiver, POA for Healthcare, DNR/POLST and any other relevant documents.

Mobile Integrated Healthcare
Recommended Residence Safety Assessment Form

Date: ____/____/____

Patient Name:

Caregiver/POA:

	YES	NO	N/A
Living Room			
Floor is free from any clutter that would create tripping hazards.			
All cords are either behind furniture or secured in a manner that prevents trip hazards.			
Phone is readily accessible near favorite seating areas.			
Emergency numbers are printed near all phones in house.			
Kitchen			

Items used most often are within easy reach.			
Step stool is present, is sturdy and has handrail.			
Bathroom			
Tub and shower have non-slip surface.			
Tub and/or shower have grab bar.			
Pathway from the bedroom to the bathroom is free from clutter and well lit for ease of movement at night.			
Bedroom			
Free from clutter.			
Light is near bed and easy to turn on.			
Phone is next to bed.			
General			
Smoke detectors in all areas of the house (each floor) and tested.			
CO detectors on each floor of the house and tested.			
Medical information is readily available and in an area emergency providers will easy find.			
All heaters are away from any type of flammable material.			
All assistive walking devices are readily accessible and in good condition.			
O2 tubing is less than 50 feet and is not a tripping hazard.			
All medications are properly stored and labeled to avoid confusion on dosage, time to take, and avoidance of missed doses.			
Equipment			
Scale is in working condition.			
Scale is in an easily accessible location.			
Home health monitor set up and working.			
The patient knows how to use the home health monitor.			
Blood glucose monitor is working.			
The patient knows how to use the blood glucose monitor.			
The patient has a working inhaler.			
The patient knows how to use the inhaler.			
Oxygen is at sufficient level.			
The oxygen is in a location to not cause a tripping hazard.			
The patient knows how to operate the oxygen and oxygen safety.			
The patient knows whom to call if the oxygen is low.			
Comments:			

With your consent, EMS has done a Safety Assessment of your home. The items checked "NO" may put you and your family at risk. You are urged to correct these at once for your own safety. This inspection does not identify future conditions such as a failure of components or human behavior which could result in an injury.

Emergency Medical Services (EMS) Residence Safety Assessment

WAIVER, RELEASE AND HOLD HARMLESS AGREEMENT

In consideration of the voluntary performance of a Residence Safety Assessment of my home located at _____, I, on behalf of myself, hereby waive any claim or cause of action of any nature that I have, or in the future may have, against any and all individual or organizational participants in the Residence Safety Assessment including but not limited to the _____ EMS provider, and it's officers, agents or employees, which claim or cause of action grows out of or results following the said Residence Safety Assessment; and I further hereby agree to release and hold harmless any and all organizational and individual participants including the aforesaid EMS provider in the Residence Safety Assessment from and against all damages of any kind, to persons or property, growing out of or resulting from a Residence Safety Assessment.

I acknowledge having read, understood, and agreed to the above waiver, and release.

Patient (print name)	Signature	Date
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POA (Legal Power of Attorney) (print name)	Signature	Date
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Witness (print name)	Signature	Date
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Mobile Integrated Healthcare
Recommended Patient Assessment Template

Patient Name _____ Date of Visit _____ Crew _____

Nature of Visit _____

Patient Complaint(s) _____

CLINICAL INDICATORS	FINDINGS	Change from Baseline (complete narrative on back)	Notification to Primary Care Provider (Name and Time)
Level of Consciousness	A V P U		
Vital Signs	BP: Pulse: Resp:		
Pain Assessment	1 2 3 4 5 6 7 8 9 10 or unable		
Temperature	Tympanic: Oral: Other:		
Weight			
Lung Sounds Respiratory Effort	<div style="display: flex; justify-content: space-between;"> <div style="border: 1px solid black; padding: 2px;">R clear L</div> <div style="border: 1px solid black; padding: 2px;">R crackles L</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div style="border: 1px solid black; padding: 2px;">R wheezes L</div> <div style="border: 1px solid black; padding: 2px;">R diminished L</div> </div>		
SPO2			
Peak Flow	Zone: Green Yellow Red		
Capnography if available			
EKG (if available and Indicated)			
Blood Glucose Level			
Urine Ketones			
Skin observation	Pale Normal Flushed		
Incision/Wound Observation and Documentation			

Recommend PCP and/or Home Health Assessment

REVIEW OF PATIENT'S MEDICATION RECONCILIATION FORM	YES	NO	Barriers to compliance/Comments	Notification to Primary Care Provider
Does patient report compliance with medication reconciliation list?				
Antibiotics				
Inhalers				
Nebulizer				
Insulin				
Are reported accuchecks within range?				
Is patient taking medication not listed on medication reconciliation list? – If yes, list				
Is patient taking medication prescribed by multiple physicians? If yes, list physician				
Does patient use more than one pharmacy? If yes, provide name and phone number				

DIET AND EXERCISE	Yes	No	Barriers to compliance/Comments	Notification to Primary Care Provider
Patient or Caregiver reports patient is adhering to prescribed diet				
Patient or Caregiver reports patient is adhering to prescribed exercise program				
Patient or Caregiver reports patient is adhering to prescribed life style changes				

Change(s)/Comments noted from Patient Assessment Record (if any)

Signature: _____

Recommend PCP and/or Home Health Assessment

EMS SYSTEM SKILLS PROCEDURES

RESIDENT / PATIENT WELLNESS CHECK

CLINICAL INDICATORS:

A resident or patient requires non-emergency services for a presumed non-urgent safety, medical or social situation. Patients may be referred by:

1. Other medical providers including but not limited to (primary care physician, discharging hospital or home health agency).
2. The resident has requested EMS/911 more frequently than expected in the preceding 12 months, or there has been a recent refusal of EMS/911 that may be high risk for adverse outcome.
3. EMS impression/assessment based on EMS/911 call(s) indicating that additional non-emergency services /resources may be of benefit.

CONTRAINDICATIONS:

Any patient for whom an emergency exists should be treated under EMS System protocols, treat within scope of practice and resources available and activate EMS/911 and implement emergency care protocols.

PROCEDURE:

1. A provider advocate will contact the resident and a voluntary meeting will be arranged with the resident/patient and a family member or caregiver if available. Request involvement of their POA (Power of Attorney) for healthcare if one exists.
2. Politely introduce yourself to the patient, family, and/or support system.
3. Determine the nature of the visit and document the referral source of the patient using the EMS System patient assessment form(s). Referral sources may include but are not limited to; dispatch agency, hospital request, primary care provider request, EMS/911 request, and home health agency request.
4. Document the requested assessments to be performed. Consider assessing fall risk and medication compliance on all visits. Assessments should include persons identified by the referral source. If visit was initiated based on dispatch frequency, assess for possible illness identified during prior dispatch calls. Requested assessments will be selected from the EMS System patient assessment guidelines, such as diabetes, heart failure, fall risk etc.
 - 4a. Refer to selected EMS System patient assessment guidelines for detailed assessment directions and document findings.
 - 4b. If the patient is diabetic, encourage daily blood glucose logs are being maintained. Asymptomatic patients with more than 2 consecutive blood glucose measurements above 350 should make contact with the primary care provider within 24 hours. If the blood glucose is above 500 or below 50 follow EMS system protocols for hyperglycemia and/or hypoglycemia. Review basic diabetic diet recommendations and advise primary care provider if there are concerns.

- 4c. If the patient has HF, verify the patient has a scale and is performing weight checks. If not, recommend mechanisms to get the patient a scale. Asymptomatic patients with unexplained recent weight gain or weight loss should make contact with their primary care provider within 24 hours. Review low sodium diet restrictions and fluid restriction if recommended for the patient. Advise the primary care provider if there are concerns.
- 4d. For asthma patients, assess if medications are available. If smoking in the home, encourage smoking cessation or outdoor smoking by family and other occupants of the home.
- 5. For patients with concern over fall prevention, encourage removal of loose rugs; observe if appropriate assist devices are present (handrails are present on all steps; restrooms have hand rails and slip resistant surfaces in showers/tubs) and communicate these issues to the patient/family. Forward information to primary care provider or social services for follow-up.
- 6. For recently discharged patients or patients needing follow-up, review and verify needed appointments noting provider and specialty, date and time. Review specific request for assessment areas and document findings on EMS System patient assessment form and communicate to case manager or primary care provider.

DOCUMENTATION:

Assessment findings should be documented on the EMS System patient assessment form, including assessment of need for additional resource involvement for the patient. These include but are not limited to; social services, dietician services, home health care assessment, Heart Failure resources, Pharmacist review, etc. Assessment findings that warrant immediate action should be forwarded immediately to the patient's primary care provider.

***REQUIREMENTS:**

Under 210 ILCS 50/3.55 and 77 IL Administrative Code 515.550, any person licensed as an EMT-B, AEMT, EMT-I, EMT-P, or PHRN shall perform emergency and non-emergency medical services in accordance with his or her level of education, training and licensure and the requirements of the EMS System in which he or she practices, as contained in the approved program plan for that system.

Maintain knowledge of the indications, contraindications, technique, and possible complications of the procedure. Assessment of provider knowledge may be accomplished via quality assurance mechanisms, classroom demonstrations, skill competency stations, or other mechanisms as deemed appropriate by the EMS System Medical Director.

Mobile Integrated Healthcare Access Diagram

**Participant Selection by
Primary Care Provider / Discharge
Planner**

Diagnosis Groups as determined by a community needs assessment (which may include but not be limited to):

- Heart Failure / COPD / Pneumonia
- Asthma
- DM – new onset or selected
- Orthopedic injuries / Falls
- Post AMI

Within the written assessment guidelines the Mobile Integrated Health Care Providers will provide:

- Home safety evaluation
- Compliance / Wellness Check
- Review of Medication Compliance / Sorting
- Evaluate caregiver involvement
- Assess for referral to other outpatient care providers(home health, PT/OT, other organizations)
- Patient education
- Patient care interventions as dictated in the Discharge Care Plan
- Coordination of care and reporting to DC Planner, Home Health Agency and or Primary Care Provider

Emergent
Life-threatening medical condition and or life safety issue.

Treat patient per EMS protocols and/or activate emergency response, transport to the closest appropriate facility upon direction of Medical Control

Urgent
There are obstacles that can be overcome, patient can remain in environment

Routine
No issues, patient can remain in the environment

Home Health Care Agency Follow Up

Discharged with a Care Plan utilizing Mobile Integrated Healthcare Providers

No Follow Up required

Scheduled home visits based on the patient's condition progressively diminishing over four (4) weeks

Coordination of care and reporting to DC Planner, Home Health Agency and or Primary Care Provider

MOBILE INTERGRATED HEALTH PROGRAM
ASTHMA ASSESSMENT GUIDELINES

CLINICAL INDICATORS:

A resident or patient requires non-emergency services for an asthma assessment. Patients may be referred by:

1. Other medical providers (i.e. primary care provider, discharging hospital, home health care or other referring agency)
2. Patient/resident request
3. EMS impression/assessment indicating that additional non-emergency services/resources may be needed
4. At-risk referral as requested by primary care provider

LIMITATION OF ASSESSMENT GUIDELINE:

Any patient for whom an emergency exists should be treated under EMS System protocols

PROCEDURE:

EMT-B, AEMT, EMT-I, EMT-P, PHRN *Refer to page 13: Requirements

1. Introduce yourself to the patient, family and /or caregiver.
2. Identify the nature of the visit and record in Patient Assessment Report (reason patient requires assessment).
3. Review the patient's discharge instructions and obtain the name of the primary care provider.
4. Assess for shortness of breath, wheezing, other signs and symptoms. Evaluate patient's medication compliance including daily use of inhalers and home nebulizer treatments.
5. Assess vital signs, SpO₂, assess peak flow and auscultate lung sounds.
6. Review discharge instructions and assess patient compliance within applicable scope of practice. Answer patient/caregiver questions and provide explanations if necessary. If needed, refer patient back to primary care provider.
7. Compare findings with patient's discharge baseline and/or previous assessment and determine if symptoms have worsened.
8. Document findings and communicate to primary care provider or referring agency.
9. If patient's condition requires action, contact the approved primary care provider/collaborator, and request that individual give instructions directly to the patient.

MOBILE INTERGRATED HEALTH PROGRAM
ASTHMA ASSESSMENT GUIDELINES

EMT-P

10. Review trending of SpO₂, Capnography and peak flow
11. If the patient's wheezing has increased, assist the patient with their inhaler or home nebulizer treatment as directed in their discharge instructions.

MOBILE INTEGRATED HEALTH PROGRAM
DIABETIC ASSESSMENT GUIDELINES

CLINICAL INDICATORS:

A resident or patient requires non-emergency services for a diabetic assessment. Patients may be referred by:

1. Other medical providers (i.e. primary care provider, discharging hospital, home health care or other referring agency)
2. Patient/resident request
3. EMS impression/assessment indicating that additional non-emergency services/resources may be needed
4. At-risk referral as requested by primary care provider

LIMITATIONS OF ASSESSMENT GUIDELINES:

Any patient for whom an emergency exists that should be treated under EMS System protocols

PROCEDURE:

EMT-B, AEMT, EMT-I, EMT-P, PHRN *Refer to page 13: Requirements

1. Introduce yourself to the patient, family, and/or caregiver.
2. Identify the nature of the visit and record in Patient Assessment Report (reason patient requires assessment).
3. Review the patient's discharge instructions and obtain the name of the primary care provider.
4. Review patient's log book of past blood sugar readings. Note blood glucose readings trending below 50 mg/dl or above 250 mg/dl. If trending above 250 mg/dl perform a blood Ketone analysis if available.
5. Obtain current blood glucose level and document findings.
6. Review patient's diet and exercise plan.
7. Assess patient's compliance with medications. Review current insulin dose and additional medications.
8. Assess patient's circulation and sensory function in extremities and compare to patient's baseline. If clinically significant changes noted, consult primary care provider.
9. Inspect skin for integrity in high risk areas. Document skin assessment.
10. Review discharge instructions and assess patient compliance within applicable scope of practice. Answer patient/caregiver questions and provide explanations if necessary. If needed, refer patient back to primary care provider.

MOBILE INTEGRATED HEALTH PROGRAM
DIABETIC ASSESSMENT GUIDELINES

11. Compare findings with the patient's discharge baseline and /or previous assessment and determine if symptoms have worsened. If the patient's blood glucose level is below the normal and patient is alert, assist patient with some food and/or drink. If patient is not alert follow appropriate EMS System Protocol.
12. Document findings and communicate to primary care provider or referring agency.
13. If patient's condition requires action, contact the approved primary care provider/collaborator, and request that individual give instructions directly to the patient.

MOBILE INTEGRATED HEALTH PROGRAM HEART FAILURE ASSESSMENT GUIDELINES

CLINICAL INDICATORS:

A resident or patient requires non-emergency services for a heart failure assessment. Patients may be referred by:

1. Other medical providers (i.e. primary care provider, discharging hospital, home health care or other referring agency)
2. Patient/resident request
3. EMS impression/assessment indicating that additional non-emergency services/resources may be needed
4. At-risk referral as requested by primary care provider

LIMITATIONS OF ASSESSMENT GUIDELINES:

Any patient for whom an emergency exists that should be treated under EMS System protocols

PROCEDURE:

EMT-B, AEMT, EMT-I, EMT-P, PHRN *Refer to page 13; Requirements

1. Introduce yourself to the patient, family and/or caregiver.
2. Identify the nature of the visit and record in Patient Assessment Report (reason patient requires assessment).
3. Review the patient's discharge instructions and obtain the name of the primary care provider.
4. Assess for chest pain, shortness of breath, peripheral edema, other signs and symptoms and patient's medication compliance.
5. Assess vital signs, SpO₂, auscultate lung sounds and perform a 12 Lead EKG if requested and available.
6. Weigh patient and assess dietary compliance.
7. Review discharge instructions and assess patient compliance within applicable scope of practice. Answer patient/caregiver questions and provide explanations if necessary. If needed, refer patient back to primary care provider.
8. Compare findings with the patient's discharge baseline and/or previous assessment and determine if the patient's shortness of breath or other HF signs and symptoms have worsened.
9. Document findings and communicate to primary care provider or referring agency.
10. If patient's condition requires action, contact the approved primary care provider/collaborator, and request that individual give instructions directly to the patient.

MOBILE INTEGRATED HEALTH PROGRAM
POST MYOCARDIAL INFARCTION ASSESSMENT GUIDELINES

CLINICAL INDICATORS:

A resident or patient requires non-emergency services for a post myocardial infarction assessment. Patients may be referred by:

1. Other medical providers (i.e. primary care provider, discharging hospital, home health care or other referring agency)
2. Patient/resident request
3. EMS impression/assessment indicating that additional non-emergency services/resources may be needed
4. At-risk referral as requested by primary care provider

LIMITATIONS OF ASSESSMENT GUIDELINES:

Any patient for whom an emergency exists that should be treated under EMS System protocols

PROCEDURE:

EMT-B, AEMT, EMT-I, EMT-P, PHRN *Refer to page 13; Requirements

1. Introduce yourself to the patient, family and/or caregiver.
2. Identify the nature of the visit and record in Patient Assessment Report (reason patient requires assessment).
3. Review the patient's discharge instructions and obtain the name of the primary care provider.
4. Assess for patient's medication compliance.
5. Assess vital signs, SpO₂, auscultate lung sounds and perform a 12 Lead EKG if requested and available.
6. If post Percutaneous Coronary Intervention, assess insertion site for infection or bleeding.
7. Assess dietary and exercise compliance.
8. Assess and review lifestyle changes.
9. Review all follow-up appointments for compliance.
10. Review discharge instructions and assess patient compliance within applicable scope of practice. Answer patient/caregiver questions and provide explanations if necessary. If needed, refer patient back to primary care provider.

MOBILE INTEGRATED HEALTH PROGRAM
POST MYOCARDIAL INFARCTION ASSESSMENT GUIDELINES

11. Compare findings with the patient's discharge baseline and/or previous assessment and determine if symptoms have worsened.
12. Document findings and communicate to primary care provider or referring agency.
13. If patient's condition requires action, contact the approved primary care provider/collaborator, and request that individual give instructions directly to the patient.

MOBILE INTEGRATED HEALTH PROGRAM
ORTHOPEDIC ASSESSMENT GUIDELINES

CLINICAL INDICATORS:

A resident or patient requires non-emergency services for an orthopedic assessment. Patients may be referred by:

1. Other medical providers (i.e. primary care provider, discharging hospital, home health care or other referring agency)
2. Patient/resident request
3. EMS impression/assessment indicating that additional non-emergency services/resources may be needed
4. At-risk referral as requested by primary care provider

LIMITATIONS OF ASSESSMENT GUIDELINES:

Any patient for whom an emergency exists that should be treated under EMS System protocols

PROCEDURE:

EMT-B, AEMT, EMT-I, EMT-P, PHRN *Refer to page 13; Requirements

1. Introduce yourself to the patient, family and/or caregivers.
2. Identify the nature of the visit and record in Patient Assessment Report (reason patient requires assessment).
3. Review the patient's discharge instructions and obtain the name of the primary care provider.
4. Assess vital signs. Assess the extremity for deformities, Skin, Temperature, Color, Circulation, Motor, Sensation, and evaluate patient's medication compliance.
5. Perform home safety inspection and verify that any patient assistive devices are in good condition and easily accessible.
6. Review discharge instructions and assess for patient compliance within applicable scope of practice. Answer patient/caregiver questions and provide explanations if necessary. If needed, refer patient back to primary care provider.
7. Compare findings with the patient's discharge baseline and/or previous assessment and determine if symptoms have worsened.
8. Document findings and communicate to primary care provider or referring agency.
9. If patient's condition requires action, contact the approved primary care provider/collaborator, and request that individual give instructions directly to the patient.

EMT-P

10. Inspect incision for signs and symptoms of infection. Compare findings with the patient's discharge baseline or previous assessment and determine if symptoms have worsened contact primary care provider.

MOBILE INTEGRATED HEALTH PROGRAM
PNEUMONIA ASSESSMENT GUIDELINES

CLINICAL INDICATORS:

A resident or patient requires non-emergency services for a pneumonia assessment. Patients may be referred by:

1. Other medical providers (i.e. primary care provider, discharging hospital, home health care or other referring agency)
2. Patient/resident request
3. EMS impression/assessment indicating that additional non-emergency services/resources may be needed
4. At-risk referral as requested by primary care provider

LIMITATIONS OF ASSESSMENT GUIDELINES:

Any patient for whom an emergency exists that should be treated under EMS System protocols

PROCEDURE:

EMT-B, AEMT, EMT-I, EMT-P, PHRN *Refer to page13; Requirements

1. Introduce yourself to the patient, family and/or caregiver.
2. Identify the nature of the visit and record in Patient Assessment Report (reason patient requires assessment).
3. Review the patient's discharge instructions and obtain the name of the primary care provider.
4. Assess for shortness of breath, wheezing, other signs and symptoms that may be different from baseline.
5. Assess for patient compliance with medications; antibiotics, inhalers.
6. Assess vital signs, temperature and auscultate lungs sounds. Review trending of SpO2, Capnography and peak flow as available. Document if patient is in red, yellow or green zone for peak flow.
7. Review discharge instructions and assess patient compliance within applicable scope of practice. Answer patient/caregiver questions and provide explanations if necessary. If needed, refer patient back to primary care provider.

MOBILE INTEGRATED HEALTH PROGRAM
PNEUMONIA ASSESSMENT GUIDELINES

8. Compare findings with the patient's discharge baseline and /or previous assessment and determine if symptoms have worsened. If the patient's wheezing has increased, assist the patient with their inhaler or home nebulizer treatment as directed in their discharge instructions and as EMS System Protocols allow.
9. Document findings and communicate to primary care provider or referring agency.
10. If patient's condition requires action, contact the approved primary care provider/collaborator, and request that individual give instructions directly to the patient.

MOBILE INTEGRATED HEALTHCARE

The Mobile Integrated Health Provider (MIHP) is a health care provider, EMT-Basic, Advanced EMT, EMT-Intermediate, Paramedic or PHRN who in coordination with community services fills the gaps between community, healthcare systems and the patient. The MIHP will identify and assist individuals to overcome barriers to receiving healthcare focusing on wellness and evaluation of specific disease processes. The MIHP will receive standardized education approved by IDPH. The curriculum can be customized to meet the needs of the community that the MIHP serves.

Mobile Integrated Health Provider Selection

Mobile Integrated Health Providers perform a unique role. Providers selected to perform mobile health should possess skills and characteristics to ensure success in the MIHP role. The following are recommendations potential candidates should have:

1. Provider with two (2)years of clinical/field experience
2. Recognized competent patient assessment skills
3. The ability to work collaboratively as a member of a health care team
4. Good communication and social skills
5. Acceptable personnel file upon review
6. Empathy

Suggested Curriculum

Day One – 8 hours

Module 1

- I. Current Models of Community Paramedicine / Mobile Integrated Health Programs
 - a. National Models
 - b. Illinois State Wide Initiative
 - c. Local Model
- II. Purpose of Mobile Integrated Health Programs
 - a. To fill the gap between health care services and community services
 - b. Reduce EMS System 9-1-1 abuse
 - c. Assist with re-admission avoidance initiatives
 - d. Support community wellness initiatives

Module 2

- I. Identification of potential clients
- II. Determine eligibility
 - a. Frequent users of the 9-1-1 system in need of social support
 - b. Patients who are non-compliant with medications and treatment
 - c. Citizens in the community requiring Wellness Checks
 - d. Client referrals from ED, Accountable Care Organizations, other health care providers and family who would benefit from a few in-home monitoring sessions to prevent readmissions
- III. Performing a Client needs assessment
 - a. Utilization of the needs assessment form

Module 3

- I. Resource Mapping – what is it?
 - a. Identification of community based resources (customized for community)
 - b. Accessing community resources, developing relationships

Module 4

- I. Performing the Home Evaluation
 - a. The Home Evaluation Tool

Module 5

- I. Special Home Equipment

Module 6

- I. The Wellness Visit Protocol

Modules 7

- I. Scenarios and role modeling
- I. Questions
- II. Post Test

Day 2 – 8 hours

Module 8

- I. Clinical Assessments with Medication Review
 - a. General evaluation
 - b. Cardiac Assessment
 - c. Medical Assessment
 - d. Respiratory Assessment
 - e. Orthopedic Assessment
 - f. Psychiatric Assessment
 - g. Neurological Assessment
 - h. Pharmacology Review and Medication Reconciliation Methods

Module 9

- I. Assessment Guidelines
 - a. Heart Failure Assessment Guideline
 - b. Asthma Assessment Guideline
 - c. Orthopedic Assessment Guideline
 - d. Status post MI Guideline
 - e. Pneumonia Assessment Guideline
 - f. Diabetic Assessment Guideline

Module 10

- II. Scenarios and role modeling
- III. Questions
- IV. Post Test

Curriculum Review

The curriculum is written to be customized to the community needs assessment. Only the modules required to perform the activities needed within the community are required. For example, to perform Wellness visits only, day one is required. To perform wellness visits and post discharge visits, both days will be required. This curriculum will be able to expand by adding modules as the program develops.