Community Paramedic™
Program Handbook

Western Eagle County Health Services District

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# TABLE OF CONTENTS

## Background
- The WECAD Model .......................................................... 1
  - Primary Care Services
  - Community-Based Services
- The Global View .............................................................. 3
  - History
  - Value
  - Programs

## Program Development
- Plan to Plan ........................................................................ 8
- Assess Program Feasibility .................................................. 8
  - State Regulations
  - Internal Commitment
  - Key Partner Commitment
- Determine how to Provide Medical Direction ......................... 10
- Assess Community Needs .................................................... 11
- Determine Program Scope ................................................... 11
  - Services
  - Personnel
  - Budget
- Engage the Community ....................................................... 15
- Develop Policies and Procedures .......................................... 16
- Plan and Implement Training ............................................... 17
- Develop an Evaluation Plan ................................................ 18
- Begin Operations ................................................................ 20
- Evaluate the Pilot Phase ..................................................... 21

## Appendices
- A. Community Paramedic Program Resources ....................... 23
- B. Work Plan ........................................................................ 24
- C. Example of a Memorandum of Understanding ................... 26
- D. Client Satisfaction Survey ................................................ 31
- E. National Community Paramedic Fact Sheet ....................... 32
- F. WECAD’s Community Paramedic Fact Sheet ....................... 33
- G. Community Paramedic Patient Referral Procedures ............. 35
- H. Release of Information Form ............................................ 36
- I. Procedure for Physician Contact While on Visit .................. 37
- J. Home Safety Assessment .................................................. 38
- K. Social Support Evaluation ............................................... 42
- L. Sample Clinical Services Policies (Wounds/Medication Reconciliation) .................................................. 43
- M. Physician Order Form .................................................... 44
BACKGROUND

Eagle County, Colorado is a rural resort community of approximately 54,000 residents located in the Rocky Mountains, over two hours west of Denver. Thirty percent of residents are uninsured, as are 54 percent of ambulance patients. Social supports are limited, especially for the elderly or those with mental health issues. And, the county is subject to extreme weather conditions, which can geographically isolate residents on any given day. These dynamics create service gaps, many of which are filled by a call to Dispatch to request an ambulance, which has become the service provider of last resort.

The Western Eagle County Health Services District (WECAD), similar to other rural EMS systems, experiences calls that aren’t true emergencies, but rather of a social service or home health nature. The District also receives emergency calls of health issues gone awry because medication wasn’t taken or an individual waited too long to seek medical attention. Some emergency calls are in response to patients just released from the hospital that were either prone to complications or didn’t understand their discharge instructions. These patients are likely re-admitted.

WECAD’s daily experiences with these types of cases prompted it to explore ways that paramedics could be more proactive in helping vulnerable residents maintain their health in order to prevent an ambulance transport. In 2009, WECAD joined with the Eagle County Public Health Agency, local physicians, and the International Roundtable on Community Paramedicine to plan and implement Colorado’s first Community Paramedic (CP) program. This handbook is designed to help other organizations start such an endeavor.
The WECAD Model

The goals of WECAD’s Community Paramedic Program are twofold: to improve health outcomes among medically vulnerable populations; and to save healthcare dollars by preventing unnecessary ambulance transports, emergency department visits, and hospital readmissions. WECAD’s Community Paramedic model has two components: 1) primary care services, ordered by a physician and conducted in a patient’s home, and 2) community-based prevention services planned and provided in concert with the local public health department.

Primary Care Services

As a way to increase availability and continuity of health care for vulnerable populations, specially-trained paramedics provide specific primary care services in the patient’s home, working through a physician’s order. The services are within the paramedic’s legal scope of practice, and the paramedics have been trained and evaluated on their ability to provide such care. This type of care is not of an ongoing nature, such as that of a home health agency, but rather each visit necessitates a discreet order with instructions for that one visit. If the provider believes the patient requires additional follow up by the Community Paramedic, they must issue another order.

While in the home, the Community Paramedic takes a patient history, assesses the chief complaint, and then confers with the treating provider on next steps. The paramedic may also conduct a home safety check and assess the need for referral to a social service agency or other community resource. A patient care report is developed and faxed to the ordering provider to be placed in the patient’s chart. This in-home type of care is perfect for many vulnerable populations including:

- The chronically ill who have a hard time getting to their medical provider’s office and frequently cancel appointments.
- Patients recently hospitalized that would benefit from a few in-home monitoring sessions to prevent complications.
- Patients in need of social supports who frequently call 9-1-1.
Community-Based Prevention Services

Community Paramedics also assist the local public health department with community-based services such as immunizations, disease investigations, blood draws at health fairs, mass vaccination clinics, and fluoride varnish applications to children. This assistance helps to increase the capacity of the department. In this two-way partnership, public health personnel also play a role in linking uninsured patients to a primary care provider, thus assisting with the physician order process described above.

The Global View

Community paramedicine is a relatively new field with local programs emerging as a response to the health care crisis. The CP model increases access to basic health care services through the use of specially trained Emergency Medical Service (EMS) personnel in an expanded role. These so-called Community Paramedics provide care in a non-urgent setting, consistent with the Medical Home Model (defined as patient-centered medical care led by a physician coordinating all aspects of preventive, acute and chronic care, using the best available evidence and technology), and under the supervision of an ordering physician or advance practice provider.

Community Paramedics expand the reach of primary care services by using a paramedic to perform procedures already in their skill set, such as: assessment (vital signs, blood pressure, labs: glucose levels, medication compliance), treatment (wound care, medication reconciliation), prevention (immunizations, fall assessment), and referral (medical and social services). Specific roles and services are determined by each community’s unique health needs, within the paramedic’s legal scope of practice, and consistent with medical direction. International programs have had success in reducing emergency transports and hospital readmissions by using the paramedic in this expanded role.

History

The term “community paramedicine” was first described in the U.S. in 2001, as a means of improving rural EMS and community healthcare; however, it is not a new concept in practice. Increasingly EMS personnel are caring for patients with non-emergent medical problems in their day-to-day role as emergency responder. For example, studies place the number of low-acuity transports (e.g., sprains or

flu-like systems) at 10–40%. Thus, it is not surprising that the field is moving toward a more community-based approach. National organizations have written about this progression for years. In 1996, a National Highway Traffic Safety Administration report described an EMS of the future with the ability not only to provide acute care, but also identify health risks, provide follow-up care, treat chronic conditions and monitor community health (Delbridge).

The 2004 article, “Rural and Frontier EMS Agenda of the Future,” provided a vision of EMS personnel providing not only a rapid response, but also filling roles in prevention, evaluation, triage, and referral (McGinnis, National Health Association Press). In 2010, the Joint Committee on Rural Emergency Care (JCREC), which is comprised of members from the National Association of State Emergency Medical Services Officials (NASEMSO) and the National Organization of State Offices of Rural Health (NOSORH), issued a discussion paper which called the community paramedicine model “One of the most progressive and historically-based evolutions available to community-based healthcare,” further praising its potential to decrease emergency department utilization, save healthcare dollars and improve patient outcomes.

Value

According to the American Academy of Family Physicians (AAFP) a health system that focuses on primary care is more effective, more efficient, and more equitable among patient populations. These benefits are demonstrated by reduced mortality rates, less frequent use of ERs and hospitals, better preventive care, higher patient satisfaction, and a reduction in health disparities. In communities all across America, provider shortages are reducing access to this basic level of care (Figure 1). In fact, the AAFP reports that the number of medical school students entering primary care has dropped 51.8 percent since 1997. According to a 2010 University of Michigan Health System study, the country may not be ready to shift to a Medical Home model because there aren’t enough primary-care doctors to handle the workload. Demand for primary care physicians is only going to increase with the 2010

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3 Joint Committee on Rural Emergency Care (JCREC); National Association of State Emergency Medical Services Officials, National Organization of State Offices of Rural Health State Perspectives, “Discussion Paper on Development of Community Paramedic Programs.” (2010)
4 Ibid.
5 Ibid.
Additionally, one quarter of the U.S. population lives in rural and remote regions, and only 10 percent of the country’s physicians practice in these areas. Compounding the problem are widespread hospital and clinic closures, an aging population, increasing cultural diversity, and the fact that rural residents are often economically disadvantaged and less healthy than their metropolitan counterparts. Many in the medical field are calling for the use of mid-level providers as a strategy to extend the reach of the physician. It makes sense to tap into EMS personnel that already live and work in these communities, in order to augment services and extend health care access.\(^8\)

Programs

Today, various forms of community paramedicine programs are operating both nationally and internationally. According to the Joint Committee on Rural Emergency Care, the expanded role of EMS personnel has already occurred on a wide scale in countries such as England, Australia and Canada. In the United States, paramedics with community-based functions are being used locally in states like Colorado, Minnesota, Texas, Nebraska, California, Pennsylvania and North Carolina. However, program services and operations vary. Community Paramedic programs are born out of necessity and as such, are based on specific community needs. The Joint Committee aptly states, “If you have seen one community paramedic program, you’ve seen one community paramedic program.”

For example, the state of Nebraska has used a “top-down” approach to develop a community paramedicine system. The effort was led by the state’s EMS Office and Office of Rural Health, which jointly advocated for state legislation as a means to provide standards for the development of local programs. Minnesota used a “middle-out” approach by developing a training program thorough a collaboration of partners, which was then offered to any interested paramedic within the state. Colorado used a “bottom-up” approach that began at the grass-roots level through a partnership between a local ambulance service and public health department, and in cooperation with the state EMS Office. The intent was to pilot this local program with the goal of replication. These programs, along with additional background on the community paramedicine field, are described in the Joint Committee on Rural Emergency Care article, “State Perspectives: Discussion Paper on Development of Community Paramedic Programs” (2010), which is available online at: http://www.nasemso.org/Projects/RuralEMS/documents/CPDiscussionPaper.pdf
Work is being conducted on a national level too. The Community Health Care Emergency Cooperative, which is representative of local programs and national organizations, has developed a standard curriculum for college credit that includes a 12-week classroom and Internet course, hands on lab sessions, and clinical rotations with oversight by medical providers. The aim of curriculum is to be portable so local programs can use their own academic institutions and community medical providers. Information can be found online at: www.communityparamedic.org/Colleges.aspx. Another good resource is the International Roundtable on Community Paramedicine, which provides an up-to-date, informational website and holds annual conferences on advances in the field: www.ircp.org.
Program Development

This handbook is based on the Colorado model, which is a grass-roots approach, led by an ambulance service, in partnership with the local public health department, and with guidance from the state EMS regulatory agency. The following is an overview of recommended steps for this “bottom-up” approach. Steps can be modified to fit local needs and aren’t necessarily linear in their time frame, in fact some may need to occur simultaneously.

Plan to Plan

The first step in developing a Community Paramedic program is to learn all you can about this up-and-coming field, the various programs in operation today, and the scope of training required for this new type of paramedic. Doing your homework upfront will allow you to begin formulating the vision and scope of your program, so that you may effectively propose the idea to stakeholders. This handbook will provide you with most of the background you will need to begin. Appendix A provides a list of resources for additional guidance during your information gathering process. Developing a Community Paramedic program requires the ongoing management of multiple logistics requiring significant legwork. To help plan and track all of the tasks, develop a work plan and fill it in to the best of your ability now, and update it as you go. A sample work plan has been attached as Appendix B.

Assess Program Feasibility and Engage Key Partners

You should determine early in the process whether such a program is even feasible in your area, given state EMS laws and the level of commitment needed internally, from local medical providers, and from a community college or university. The following section provides a list of initial contacts and commitments you will need.

Program Feasibility Checklist:

✓ Are there any state regulatory barriers that need to be dealt with first?
✓ Does internal buy-in exist among EMS Personnel, Medical Director and Board?
✓ Are local physician practices willing to participate? Train paramedics?
✓ Is a local college or university available to teach the Community Paramedic course?
State Regulatory Agency

Once you have formed your initial program vision, begin by talking with your state EMS regulatory agency to see if there are any issues that either precludes a CP program from operating in your state or that need to be dealt with first, such as licensing. Because formal Community Paramedic programs are new, the agency may not be sure where the program fits regulations-wise. Your education and input may be needed to help resolve the issue.

Ambulance Service

Next, propose the idea internally. You will need commitments from everyone within the organization including the agency director, EMS personnel, board members and medical director. The paramedics will be required to participate in a fairly rigorous training program, both up front and in an ongoing manner. Make sure personnel are willing to take on this additional role. Obtain assurances from the board of directors that: 1) they will support the organization in focusing on program development, which could take 1-2 years to operationalize; and 2) they understand that internal resources, including funding, may need to be shifted toward program support. Finally, gain a commitment from the medical director that they will provide the medical oversight, including the development of quality assurance mechanisms, advising the clinical training process, and evaluating the competency of the Community Paramedic’s skills.

Medical Providers

Next, approach medical providers to make sure there is enough physician buy-in to make the program worth developing. The participation of primary care physicians is key to the success of the grass roots model since they have a major role in training the Community Paramedics during clinical rotations, and providing the orders to use them. Physician commitment will be one of the greatest determinants of program feasibility. If your program wishes to also make clinical assistance available to the local public health department or assist them with prevention activities, they should also be engaged at this step. Note that not all public health departments offer client-level medical services, but they are a good partner nonetheless, and may be able to help you recruit physicians for the program. Eventually, you will want to formalize relationships with these entities through a legal agreement such as a memorandum of understanding (MOU). (See Appendix C for an example.)
College or University

In order to utilize the Community Health Care Emergency Cooperative’s Community Paramedic Curriculum, training must occur through a community college or university willing to teach the curriculum, coordinate the clinical rotations, and provide academic credit (available in 2012). You should gain commitment from an academic institution early in the process, to make sure that training is available for the program. The director of the EMS division at the institution will be the best contact and should also be the person to request the curriculum from the Cooperative.

The college or university will need to employ and pay for the faculty member that will be teaching the course. Ideally, the course instructor will have an understanding of the EMS system, the roles of the various levels of providers (EMT, paramedic, public health nurse, social worker, etc.) plus, experience working within the health care system, and familiarity with community resources. Because the course is set up to have online sessions, the institution should also have a system that can accommodate this, like an online “Blackboard.” Note that a legal agreement (e.g., MOU) with the institution is critical to have in place before training begins.

🎯 Determine How to Provide Medical Direction

The program’s Medical Director will have specific duties related to the Community Paramedic program. For example, they will evaluate the Community Paramedics after completion of training, annually, and as needed. A sample evaluation tool is provided within the Community Paramedic Curriculum. They will also perform chart reviews and provide feedback to the paramedics. This process should be rigorous at first, by potentially looking at all clients during the program’s pilot phase (for example, the first 50 patients), and then determining the criteria for regular reviews after that. During chart reviews, the medical director can evaluate whether the CPs are assessing the patients appropriately, documenting appropriately, communicating adequately with the ordering physician, making referrals, following policies and procedures, and meeting general patient and provider needs. Client satisfaction surveys are one tool that can help the Medical Director assess patient care on many levels. A sample tool is provided as Appendix D. Patient case studies performed with the paramedics for a high-risk type of visit will help to build judgment and continue the learning process. The medical director may also be part of call down list if the ordering physician is not available when the home visit is conducted.
In WECAD’s program, a local primary care physician has agreed to share the medical oversight with the organization’s medical director. Additionally, ordering physicians that are participating in the program are teaching and evaluate skill competencies during clinical rotations (All of these roles are clarified through a Memorandum of Understanding with each physician practice).

Assess Community Health Needs

The Community Paramedic program will be better able to make the case for its existence, obtain resources, and have more of an impact on community health overall, if services are based on a needs assessment. A community needs assessment can determine:

- The leading causes of preventable morbidity and mortality
- Gaps in health care services
- Demographics of the populations most impacted by the gaps
- Characteristic of those who most frequently use the ambulance service
- Most frequent conditions requiring hospital readmission
- The greatest health care needs as seen by local medical providers

Your local public health agency has experience conducting health assessments and could be a good resource for this activity. The department regularly tracks community health outcomes such as death, injury, and disease rates, which could be used for program planning and evaluation. For example, areas with a high rate of senior falls may wish to add a safety check to Community Paramedic home visits. Patient databases at the hospital and ambulance services are two sources of queryable data. The ambulance service database can provide the medical description and demographics of patients that place frequent 9-1-1 calls. The hospital database may be able to provide a list of the conditions most frequently requiring hospital readmission that could be targeted for a CP visit. Finally, one-on-one medical provider interviews can provide qualitative information about how a CP program can best help them fill health care gaps and serve their most vulnerable patients.

Determine the Scope of the Program

During this phase, you will want to determine the types of services to be offered, personnel needs and program budget, based on the results of the community needs assessment, services provided in the Community Paramedic Curriculum, and the level of funding your agency either has or will be able to raise toward this program.
Services
The first step is to determine whether your Community Paramedics will provide in-home patients visits and/or community-based services, as both require a different type of clinical training. Be sure that the services you are envisioning are within the legal scope of practice for your paramedics, based on state regulations. Eventually, the program’s medical director will need to approve these. Common services include: assessment (vital signs, blood pressure, labs such as glucose levels, medication compliance), treatment (wound care, medication administration), prevention (immunizations, in-home fall prevention) and referral (medical and social services).

Personnel Needs
Each program will need to determine the number of Community Paramedics and their schedule, based on the needs assessment, frequency of ambulance calls, and population size. Community Paramedics can be scheduled based on a couple of different scenarios: 1) If the agency has enough EMS personnel, the Community Paramedic could be assigned discreet and prescheduled times to see clients when they are not designated as an emergency responder; 2) If the Community Paramedic has a dual role of emergency response, consider scheduling them on the second response team at pre-determined times to allow more prescheduled opportunities to see clients.

In terms of other types of personnel, the program will require programmatic and medical oversight, program coordination, scheduling, fundraising, and evaluating. Agency personnel or contractors may be used to fill these functions, and a single position may fill more than one function; for example, the program coordinator may also schedule patients. The following are examples of positions used within the WECAD program:

- Medical Director
- Program Director
- Community Paramedic
- Program Coordinator
- Scheduler
- Evaluator
- Grant Writer
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Program Handbook

- Quality Assurance Coordinator

Budget and Fundraising Needs

Based on the services you plan to offer and the staffing patterns necessary to support them, develop a program budget and fundraising plan. Determining whether new personnel need to be hired will depend on the scope of the program and population of the service area. In some cases, it may be possible to shift in-house personnel. For intermittent functions like grant writing, a contractor may make the most sense dollar-wise. For the operational budget, the need for new items such as a daily means of transportation (non-ambulance vehicle) and primary care equipment will need to be determined. Tuition costs and training supplies will also need to be quantified for the Community Paramedic course provided by the local community college or university, if the agency will be the entity to pay for such training. Examples of potential line item budget expenses are provided as Figure 2.

After developing a budget, it may be necessary to create a fundraising plan with targets set by dollar amount and deadlines. A multi-year budget can inform fundraising targets for consecutive years. Sources of funding may include local, state and federal governments, foundation grants, and donations from community partners. In the future, it may be possible to bill Medicaid and Medicare.

CP Program Tip

In WECAD's experience, patients of the Community Paramedic program are uncomfortable with an ambulance pulling up to their house for a home visit, because it causes unnecessary concern to neighbors. WECAD obtained an SUV through a grant and then outfitted it with lighting, sirens, lettering and radio, for use by the CP Program.
<table>
<thead>
<tr>
<th>Category</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PERSONNEL</strong></td>
<td>Program Director</td>
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<td></td>
<td>Community Paramedic(s)</td>
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<tr>
<td></td>
<td>Quality Assurance Coordinator</td>
</tr>
<tr>
<td></td>
<td>Program Coordinator/Scheduler</td>
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<tr>
<td><strong>CONSULTANT/CONTRACTUAL</strong></td>
<td>Medical Oversight <em>(Licensed physician)</em></td>
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<tr>
<td></td>
<td>Evaluation</td>
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<tr>
<td></td>
<td>Grant Writing</td>
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<tr>
<td><strong>EQUIPMENT</strong></td>
<td>Otoscope <em>(with camera to send to physician)</em></td>
</tr>
<tr>
<td></td>
<td>Stethoscope <em>(digital to send read-out to physician)</em></td>
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<td></td>
<td>Temporal thermometer</td>
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<tr>
<td></td>
<td>Pulse oximeter</td>
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<tr>
<td></td>
<td>Digital camera <em>(to send pictures to physician, e.g. wounds, cellulitis, home safety risks)</em></td>
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<tr>
<td></td>
<td>Portable adult and baby scales</td>
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<tr>
<td><strong>LAB SUPPLIES</strong></td>
<td>Dressing changes</td>
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<td></td>
<td>Blood draw</td>
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<tr>
<td><strong>TRAVEL</strong></td>
<td>Non-emergency vehicle <em>(lettering, lights, radio if new)</em></td>
</tr>
<tr>
<td></td>
<td>Motor vehicle insurance/gas</td>
</tr>
<tr>
<td><strong>INSURANCE</strong></td>
<td>Additional malpractice insurance <em>(Check with insurance company)</em></td>
</tr>
<tr>
<td><strong>UNIFORMS</strong></td>
<td>Community Paramedic uniforms</td>
</tr>
<tr>
<td><strong>TRAINING</strong></td>
<td>Tuition, text books and supplies</td>
</tr>
</tbody>
</table>
Engage the Community

A community engagement process is a good way to assess the level of community support, build advocates for the program, identify community resources, and determine potential barriers. Strategically anticipate how you will use different entities and who needs to know about the program early, in order to support it. Begin the process by developing key messages for specific audiences and determining how to target them.

**CP Program Tip**

Before approaching stakeholders, prepare the following materials:
- Local community health assessment
- Program vision
- Fact sheet (National Sample: Appendix E; WECAD Sample: Appendix F).

Prepare to make the argument that the Community Paramedic program is not meant to replace a primary care provider, public health nurse or home health agency, but rather is intended to be complimentary to the health care system in breaking down silos and filling gaps.

It is particularly important to build relationships with the public health department and social service agencies early in the process, as these types of organizations can assist with community needs assessment, client referrals, and are likely to become champions for the program. Whether your program provides community-based services or not, the local public health department can also play a supporting role by helping to conduct a community health assessment to determine the population’s health status and gaps within the health care system. Since a Community Paramedic program can be a good strategy to fill gaps and promote public health values such as the Medical Home Model and reducing barriers to care, partnering can benefit both entities. The health department also probably has strong partnerships with key medical providers and help to get them on board. Additionally, the department likely has experts in the realm of program evaluation and can suggest different methodologies and assist with the CP Program’s process.
Social service agencies offer programs that may benefit the Community Paramedic client. Because the Community Paramedics get a first-hand look at the client’s home environment, they are in the perfect position to assess the types of referrals that may benefit the client such as Medicaid enrollment, mental health treatment, case management, and assistance with food and home utilities. Social service agencies will be integral in educating Community Paramedics during the training phase, about the types of community resources available and how to make referrals.

Buy-in is also beneficial from other medical providers like home health agencies and physician practices that are not participating in the CP program, so that they understand the niche of a Community Paramedic and so-called turf issues can be avoided. Other types of organizations that should be engaged include local governments, foundations, civic groups, the state’s Office of Rural Health and other organizations that may provide funding, advocacy or other types of support.

Another way to engage stakeholders is to develop a community advisory committee that meets regularly. This group can be the eyes and ears of the community, providing insight, feedback and direction. The committee may have representation from medical providers, health and human service agencies, gatekeepers to underserved communities, consumers, elected officials and other community leaders.

**Develop Policies and Procedures**

Because Community Paramedics are working in an expanded role and with new community partners, it will be important to develop policies and procedures that provide explicit boundaries around the program, clarifying what it is and what it is not. Community Paramedics should always follow the policies and procedures of their larger organization; however, P&Ps specific to the Community Paramedicine program will also need to be developed. In general, policies and procedures can:

- Outline the new role of the paramedic, stating that a paramedic is not to provide a service out of their scope of practice, and for which they have not been trained and evaluated.
- Define program services and operational policies such as response time.
- Outline the process for receiving requests to utilize Community Paramedics (Appendix G). (Providers should also be trained on the process.)
Require the use of a Release of Information Form to protect patient confidentiality before a Community Paramedic begins care (Appendix H).

Define the conditions under which the Community Paramedic may practice (within a specific service area, serving only providers with an MOU agreement in place, and in which settings—home or public health clinic).

Provide the steps for when physician contact is needed during a visit and the ordering physician is not available (Appendix I).

Define service-specific procedures such as:
- Home safety assessment (Appendix J)
- Evaluation for social support (Appendix K)
- Clinical services (wound care, medication compliance and reconciliation, etc.) (Appendix L)

The Community Paramedic Curriculum provides general guidelines to the paramedics about these types of policies during training. Individual organizations should develop their own policies, which can stand alone or be woven into procedures, job descriptions, legal agreements, etc.

Plan and Implement Training

There are three levels of training to prepare a paramedic to provide primary care through a physician’s order: 1) a 12-week didactic college course, 2) hands-on lab sessions, and 3) clinical rotations. The curriculum used for the didactic course is available through the Community Health Care Emergency Cooperative (http://communityparamedic.org/Colleges.aspx) and must be taught through a college or university. The course consists of approximately six classroom presentations and 2-3 hours of weekly online sessions.
In order to pass the course, the individual paramedic must perform 32 hours of lab sessions and 100-150 hours of clinical time, depending on the specialties chosen. The clinical time is organized into two levels of training: The first focuses on the general clinic setting; the second concentrates in specialty areas, depending on the community’s needs and program’s scope. The college or university will coordinate the matching of the students with clinical sites; however, the Community Paramedic program should have already done the legwork in identifying and engaging local providers, to assure the clinical rotations are successful. Whenever possible, it will help to make the program successful if medical practices that plan to use Community Paramedic services provide training during the clinical rotation phase, so a level of trust can be established between the paramedic and ordering physician.

Before the clinical rotations can be arranged, the scope of Community Paramedic services will need to be determined, including the skills and procedures to be taught by the providers. Services need to be within the legal scope of practice and should be approved by the ambulance service’s medical director. Training and lab time should focus exclusively on the procedures that are going to be offered by the program. The Curriculum highlights primary care services already being performed by Community Paramedics. Local programs will need to make sure these fall within their state regulatory guidelines before including them in the scope of services.

Develop An Evaluation Plan

Developing an evaluation plan during the planning process will provide many benefits to the program. First, it will assure that client databases are in place and collecting the right data, beginning with the first patient. Also, program evaluation at its basic level, will be required in any grant application for future funding, and an evaluation plan will make grant writing easier.

The first part of the evaluation plan should include a method for tracking patients in a queryable manner. If the organization already has a client database, such as an electronic medical record, this could be used; otherwise a spreadsheet program such as Excel or Access would also work if client information were entered after each visit. The database should track variables such as client demographics (age, gender, ethnicity, language, insurance status), services requested on an order, patient diagnosis, referring physician, time and date of call, chief complaint, referrals to other services by a Community Paramedic, and outcomes (e.g., ambulance transport, physician follow-up, re-
admission, no follow-up necessary). Collecting and analyzing this type of information will meet most types of grant requirements. This information can also inform programming in terms of staffing patterns, budget, training needs, gaps in service, and types of patients served. Descriptive statistics can then be used to illustrate the program such as:

- Percentage of uninsured, Medicaid and Medicare patients
- Percentage of Spanish-speaking patients
- Age range of patients
- Number of visits (total and average per patient)
- Leading types of chief complaints (tracked by number of events)
- Leading outcomes of visits (tracked by number of events)

Patient databases at the hospital or within the ambulance service can also illustrate program outcomes such as a change in the level of non-emergency transports and hospital readmission rates. The reduction in non-emergency transports can be targeted as a program goal by using the ambulance patient database to determine frequent callers to 9-1-1 for non-emergency transports, then coordinating with their physician to provide an intervention, which may include linking to social service agencies. Non-emergency transports can also be a baseline measure for the program, to determine CP program impact over time.

The hospital may have data that shows the most prevalent conditions likely to cause a readmission. The CP program, in cooperation with the discharging physician, can then target patients with these conditions. This can also be a baseline measure for the program to determine impact over time. If the program serves enough patients to impact county-level health outcomes, such as a reduction in injury or death rates, these indicators could be tracked and measured with the help of public health data sites.

Also, qualitative information can supplement the quantitative data by documenting case studies to illustrate outcomes and the value of the Community Paramedic program. In its most basic form, this is a narrative, which tells the story of particular CP cases. Case studies should meet certain criteria such as those where a negative outcome for the patient was either clearly or possibly avoided, due to the intervention of the Community Paramedic. Information can be elicited through an interview with the
Community Paramedic and/or ordering physician, to document the case. Case studies can include patient demographics, presenting problem, the CP intervention and resulting outcomes. Names should not be used to protect patient confidentiality.

**Begin Operations**

Once legal agreements are in place with providers, and paramedics have been clinically trained and evaluated, the scheduler can begin accepting orders from the physician or requests from the public health department. An example of a Physician’s Order Form is provided as Appendix M. Patients are served in one of two ways: 1) during a home visit through the medical provider’s order; 2) in a community or clinic setting through a partnership with the local public health department.

**Physician’s Office**

Physicians order home visits through the agency scheduler, who then arranges the appointment with the patient. The visit is set up as a medical provider consultation. The ordering provider will fax the scheduler a packet to include medication list, medical history, supporting documents, and other pertinent medical information. The Community Paramedic will respond to the order between 8:00 am and 5:00 pm within 24 – 48 hours of receipt, based on urgency. During the home visit, the Community Paramedic takes a patient history, assesses the chief complaint, and then confers with the treating provider on next steps. If the treating provider is unavailable for consultation, a call-down list triggered to assist the CP in getting the medical recommendations from either another physician within the practice or alternative physician according to policy (Appendix I.)

Once the visit has occurred, the Community Paramedic communicates to the physician through the patient care report, which then becomes a permanent part of the permanent medical record. Physicians may only order services, which are in within the program’s scope of services (services within the paramedic’s scope of practice, for which they have been trained and evaluated as able to perform satisfactorily). Visits are scheduled during regular business hours and initial visits are scheduled for one hour.
Local Public Health Department

Community Paramedics may assist a local public health department with such services as immunizations, fluoride varnish application, blood draws for screenings, blood pressure checks and communicable disease investigations. The paramedic works with a registered nurse and the health department has oversight from the department’s medical director, who should be a licensed physician. Community Paramedics may be of particular use for surge capacity during a disease outbreak when mass vaccination/prophylaxis and investigation is needed or when a clinic is short staffed. The Community Paramedic’s agency and public health department should agree on a process for requesting the services of a Community Paramedic, to be coordinated through the scheduler.

Evaluate the Pilot Phase

The program should plan to have a 1-2 month pilot phase to test how all of the systems are working. At the end of the pilot phase, the systems should be evaluated and mid-course corrections made. An evaluation of the pilot period can assess the following:

- How the referral process is working for medical providers (interviews)
- Response time of the Community Paramedics (tracking forms or EMR)
- Client satisfaction (surveys or interviews) (Appendix D)
- Quality assurance (case/chart reviews)
- Program evaluation: Does patient database capture all the variables? (Database query)

Different aspects of this evaluation can be woven into an ongoing quality assurance plan and conducted on a regular basis.
APPENDICES
Appendix A

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](http://www.IRCP.org)

- **Joint Committee on Rural Emergency Care:**
  National Association of State EMS Officials & National Organization of State Offices of Rural Health

- **Community Health Care Emergency Cooperative's Community Paramedic Curriculum:** [www.communityparamedic.org/Colleges.aspx](http://www.communityparamedic.org/Colleges.aspx)

- **WECAD Community Paramedic Program Development:**
  - Chris Montera, Chief, Western Eagle County Health Services District
    E-mail: cmontera@wecadems.com
    Website: [www.wecadems.com/cp.html](http://www.wecadems.com/cp.html)
  - Caring Anne Consulting, Anne Robinson, RN, President
    Public Health Nurse Consultant
    E-mail: ar@caringanne.com
    Website: [www.caringanne.com](http://www.caringanne.com)
  - Silver Street Consulting, Jill Hunsaker Ryan, MPH, Principal
    Public Health Consultant
    E-mail: [www.silverstreetconsulting.net](http://www.silverstreetconsulting.net)
    Website: [silverstreetconsulting@gmail.com](mailto:silverstreetconsulting@gmail.com)
## Appendix B: Work Plan Template, Months 1-12

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<th>Activities</th>
<th>Person(s) Responsible</th>
<th>Activity Due Date: Place X by Month(s)</th>
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<tr>
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<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan to Plan</td>
<td>Background materials</td>
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<tr>
<td></td>
<td>Work plan</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Determine Program Feasibility/Begin to Engage Key Partners</td>
<td>State EMS Office</td>
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<tr>
<td></td>
<td>Internal Leadership, Staff</td>
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</tr>
<tr>
<td></td>
<td>Medical Community</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>College/University</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Determine Medical Direction/Quality Assurance</td>
<td>Develop a plan</td>
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<tr>
<td>Assess Community Health Needs</td>
<td>Engage health department</td>
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</tr>
<tr>
<td></td>
<td>Develop an assessment plan</td>
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<tr>
<td>Determine Program Scope</td>
<td>Services</td>
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<td>Budget</td>
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<tr>
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<td>Need for Fundraising</td>
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</tr>
<tr>
<td>Engage Stakeholders</td>
<td>Identify</td>
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</tr>
<tr>
<td></td>
<td>Engage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Form advisory committee</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Develop Policies/Procedures</td>
<td>Identify needed policies/procedures</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Develop, incorporate into training</td>
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<td></td>
</tr>
<tr>
<td>Plan for Training</td>
<td>Commitments for clinical rotations from providers</td>
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<tr>
<td></td>
<td>Plan training with college/university</td>
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### Appendix B: Work Plan Template, Months 13-24

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<td>Clinical rotations</td>
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<td>Health Dept. trainings</td>
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<td></td>
<td>Evaluate paramedics</td>
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<tr>
<td>Develop an Evaluation Plan</td>
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</tr>
<tr>
<td></td>
<td>Client database tracking</td>
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</tr>
<tr>
<td></td>
<td>Outcomes and how to measure</td>
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</tr>
<tr>
<td></td>
<td>Case study procedures</td>
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</tr>
<tr>
<td>Begin Operations</td>
<td>MOUs in place with providers</td>
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<td>Scheduling procedures in place, providers trained</td>
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</tr>
<tr>
<td></td>
<td>Begin accepting patients</td>
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</tr>
<tr>
<td></td>
<td>Conduct chart reviews</td>
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<tr>
<td>Evaluate the Pilot Phase</td>
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<td></td>
<td>Referral process</td>
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<td>Patient satisfaction</td>
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<td>Quality assurance procedures</td>
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<td></td>
<td>Patient database tracking</td>
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<td></td>
<td>Make corrections to systems</td>
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Done (X)
MEMORANDUM OF UNDERSTANDING
COMMUNITY PARAMEDIC PROGRAM

This Community Paramedic Program Agreement ("Agreement") is entered this ____day of ____________, 20__, between (COMMUNITY PARAMEDIC PROGRAM) and (MEDICAL PROVIDER), herein being referred to collectively as, the "Participants."

WHEREAS, the Participants share a mission to improve the health of residents in (NAME OF SERVICE AREA); 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 community paramedic program in terms of providing clinical training and issuing orders; and

WHEREAS, (MEDICAL PROVIDER) desires to participate in (PROGRAM’S) 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. (MEDICAL PROVIDER) agrees to provide a clinical rotation for a mutually agreed upon number of community paramedics, in the areas of family practice and pediatrics, based on the attached clinical rotation guidelines (Attachment A). Activities will include training then evaluating the community paramedic’s ability to correctly perform each procedure. (MEDICAL PROVIDER) may provide additional training hours if both parties agree that it would be mutually beneficial to the program.

g. 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 (MEDICAL PROVIDER).

h. Participants agree to run data requests on certain measurable outcomes for use by both parties. Data will be presented in aggregate without patient identifiers. (CP PROGRAM) will share program evaluation results with (MEDICAL PROVIDER).

i. (MEDICAL PROVIDER) 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 24 – 48 hours of receipt, and based on urgency and availability, unless otherwise agreed upon by the issuing provider. (MEDICAL PROVIDER’S) physicians and medical providers shall provide medical oversight and have ultimate responsibility regarding their patients in the program.
f. (MEDICAL PROVIDER) shall provide a representative to the Community Paramedic Advisory Committee, which meets quarterly.

g. (MEDICAL PROVIDER) shall participate in case reviews when appropriate, in order to improve the quality of the program and document specific outcomes for evaluation purposes.

h. (CP PROGRAM) shall provide the medical oversight for the program through its Medical Directors, Colorado-licensed physicians.

i. (MEDICAL PROVIDER’S) participating physicians shall sign Attachment B agreeing that they understand the program and the procedures available to be performed. Attachment B can be amended with additions or deletions of physician’s signatures on an as needed basis without the need to change this agreement.

j. (MEDICAL PROVIDER) shall provide proof of a certificate of liability insurance for Medical Malpractice listing all physicians participating in the program.

II. 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 Colorado Governmental Immunity Act, Section 24-10-101, et seq., C.R.S. (“CGIA”). Said insurance policies shall cover officers, employees, agents and volunteers of the Participants. 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 of limitation period which might apply to acts, errors or omissions of a party during the term of this Agreement, or 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. 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.

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.

III. Compensation

The Participants understand that no compensation will occur for community paramedic services or the training they receive, unless a modification is made to this contract.

IV. 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.
Appendix C: Sample Provider Agreement, Continued

V. Termination of Agreement

Either party may terminate this Agreement at any time and for any reason in writing with thirty (30) days notice.

VI. 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.

VII. 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.

VIII. 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.

IX. Enforcement, Jurisdiction and Venue

This Agreement shall be governed and construed in accordance with the laws of the [STATE OF PROGRAM, and in addition to any other remedy, may be specifically enforced. Jurisdiction and venue for any suit, right or cause of action arising under, or in connection with this Agreement shall be exclusive in [LOCATION OF PROGRAM, STATE].

X. Responsibility for Acts of Employees and Promise to Indemnify

Each party will be solely responsible for its acts and omissions and the acts and omissions of its employees, agents, officers and volunteers in the performance of its obligations under this Agreement, and shall indemnify and hold the other party harmless from and against any and all demands, losses, liabilities, claims, or judgments, costs and expenses, including but not limited to reasonable attorney’s fees, arising out of any act or omission of the party, its employees, agents, officers and volunteers in the performance of its obligations under this Agreement.

XI. Third Party Beneficiary

Nothing herein expressed or implied is intended or should be construed to confer or give to any person or entity other than [CP PROGRAM] or [MEDICAL PROVIDER] and their respective successors and assigns, any right, remedy or claim under or by reason whereof of by reason of any covenant or condition herein contained.

XII. 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:
XIII. 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.

XIV. 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.

XV. 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.

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

(PROGRAM)

By: ________________________________
Title: ________________________________
ATTEST: ________________________________

(MEDICAL PROVIDER)

By: ________________________________
Title: ________________________________
ATTEST: ________________________________
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<td>Otoscope</td>
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<td>Identifying Red Flags</td>
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</tr>
<tr>
<td>65 + years</td>
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Client Satisfaction Survey

Western Eagle County Health Services District (WECAD) is committed to providing you with excellent service and care. We are a community organization that is tax supported by our residents and home owners. It is our goal to maintain the highest level of customer service, training, skills, and compassion to all of our patients and families. Please take a few moments and complete this short survey. Your responses will be assured confidentiality.

Reason for Service: 911 Call □ Community Paramedic Visit □ Transferred from Clinic to Hospital □

Please rate the following areas on a scale of 1 – 5 (1 Strongly Dissatisfied to 5 Very Satisfied)
Circle only one answer per line.

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<tr>
<th></th>
<th>Strongly Dissatisfied</th>
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<th>Very Satisfied</th>
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<td>3</td>
<td>4</td>
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<td>3</td>
<td>4</td>
<td>5</td>
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<td>2</td>
<td>3</td>
<td>4</td>
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<td>Overall satisfaction with WECAD</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
<tr>
<td>Satisfaction with care you received at Emergency Room after we ended our care</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>N/A</td>
</tr>
</tbody>
</table>

If you do have a concern about our services provided, please contact our office and speak with Chief Christopher Montero or Deputy Chief Christopher Dick or we will call you back at the number you provide.

Name: ____________________________ Phone: ____________________________

Please provide name and phone number. (Optional and Confidential)

Additional Comments:

________________________________________________________________________
________________________________________________________________________

Thank you for your time and comments about our service.

Version 09/2011

Community Focused Emergency Medical Services
www.wecadems.com

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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 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 Community Paramedic 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.

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
- Community Paramedic 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 Community Paramedic replace current healthcare systems like home health care or primary care physicians?
A: No. Community Paramedic 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 Community Paramedic have the right training to provide primary care?
A: Additional training is provided to Community Paramedics 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 Community Paramedic vs. a primary care provider?
A: No. A Community Paramedic provides care under the supervision of a physician, so the quality of care is consistent with care provided in a clinic setting.
Community Paramedic Fact Sheet

Problem Statement:
- Access to healthcare and particularly primary care services is a growing concern. Primary care providers are in short supply, and the uninsured population is on the rise.
- Uninsured patients are less likely to seek out preventive care services, and are more likely to go to the emergency room for non-urgent care, increasing the cost of healthcare.
- In rural areas, the problem is exacerbated because of a higher rate of uninsured, compared to urban settings, and shortage of healthcare providers.

Opportunity:
- To address the decrease in access to primary care services, it is necessary to evaluate current resources within communities and explore innovative solutions. The Community Paramedic model is a proven solution that provides essential primary care services for vulnerable populations.
- Paramedics have the training, expertise and scope of practice to provide primary care services such as assessments, blood draws, wound care, diagnostic cardiac monitoring, fall prevention, medication reconciliation, and post-operative follow up. They also have the experience of taking health care into the home.
- Internationally, Community Paramedic programs have demonstrated increased health outcomes and cost savings. Many countries are providing Emergency Medical Service (EMS) personnel with additional training to expand into community-based services.
- EMS personnel are already integrated throughout the healthcare system, allowing them to easily provide primary care services within their scope of practice.

What the Community Paramedic model offers:
- Enhanced utilization of a healthcare resource under the current scope of practice.
- Increased efficiency in terms of managing patients in a primary care setting.
- Coordinated and integrated care with physician’s offices, hospitals, home health agencies, long term care facilities, and public health departments.

The Community Paramedic model will NOT:
- Replace current healthcare systems or positions.
- Change the current defined scope of practice of the EMS Personnel.
- Remove patient populations from healthcare providers.
- Decrease the level of care provided.

-Over-
Health Care Statistics

Primary care shortage
  o In July 2011, 52 of Colorado’s 64 counties (81%) were either fully or partially designated as a Health Professional Shortage Area.  

Uninsured/Underinsured rates
  o In 2010, 14.7% (342,122) of Colorado residents reportedly did not see a doctor in the previous 12 months, due to costs.  
  o During 2009/2010, 22% of Eagle County residents were reportedly uninsured, compared to Colorado at 15.4%.  
  o In 2005, 68% of Eagle County’s Latino households were reportedly uninsured.

Access to care statistics
  o 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.  
  o In 2005, 38% of Eagle County households reportedly had trouble accessing health care.  
  o In 2005, 43% of Eagle County residents reportedly were unable to access dental care.

Readmission rates
  o 50.2% of patients who were readmitted to the hospital had no follow-up care with primary care physician from time of discharge to time of readmission.  
  o In 2009, the cost to Medicare of unplanned re-hospitalizations was $22.9 billion nationally.

Cost of healthcare in ER
  o ER costs per-visit are generally 3 times higher than comparable care in an outpatient clinic.  
  o According to Johns Hopkins University, between 1997 and 2007, 13 percent of trauma patients returned to the emergency room within a month of discharge for routine follow-up care such as dressing changes.  
  o In Colorado in 2008, 80% of ER visits were not true emergencies.

Preventive services
  o In 2005, 56% of Eagle County households were reportedly affected by chronic health issues.  
  o In 2009/2010 32% of Eagle County residents were reportedly overweight & 10.5% were obese.  
  o According to the Centers for Disease Control, vaccination is the number one method of preventing disease, disability, and premature death.

1. Colorado Department of Public Health and Environment, Primary Care Health Professional Shortage Area Map. Website: www.cdphe.state.co.us/pp/primarycare/shortage/pchpsa.pdf  
3. Colorado Health Information Dataset (CoHID,), Behavioral Risk Factor Surveillance System, Colorado Department of Public Health and Environment. Website: http://www.cdphe.state.co.us/cohid/brfss.html  
Community Paramedic Patient Referral Guide

1. Provider talks with patient about follow-up with a community paramedic from WECAD.

2. Provider requests patient sign the consent/authorization to release health information form.

3. Provider completes the community paramedic patient referral form and lab form if indicated. (Use existing laboratory request form, as this is the form the lab will receive with the specimen.)

4. Provider faxes the following to the CP Patient Scheduler: Release of information form, current history and physical, medication history, hospital discharge orders, immunization records or any other medical record applicable to the community paramedic visit. (Please include the patient’s medical record number.)

5. Scheduler will verify with physician that all information has been received.

6. The community paramedics will make every effort to see the referred patient within 48 hours of the referral unless the patient is in urgent need of medical follow-up.

7. Scheduler will call the patient to arrange appointment time/date.

8. Scheduler will coordinate with the community paramedics to arrange patient visit.

9. Scheduler will call or fax the appointment dates to the provider offices once a week.

10. Community Paramedic will complete patient visit at appointment time arranged.

11. Community Paramedic will complete patient care report.

12. Scheduler will fax patient care report back to provider office within 24 hours of visit.
## Release of Information Form

**PATIENT INFORMATION**

<table>
<thead>
<tr>
<th>Patient’s Last Name</th>
<th>First</th>
<th>Middle</th>
<th>DOB</th>
</tr>
</thead>
</table>

**INFORMATION**

- [ ] Consult
- [ ] Labs
- [ ] Immunization Record
- [ ] Discharge Summary
- [ ] Physician Progress Notes
- [ ] Other as specified below: [ ]
- [ ] Emergency Department Report
- [ ] MRI Report
- [ ] EKG Tracings
- [ ] Operative Report
- [ ] Graphic Record
- [ ] X-Ray Report
- [ ] History and Physical
- [ ] X-Ray MRI

<table>
<thead>
<tr>
<th>Date of Order</th>
<th>Purpose of Release</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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**

- [ ] From the date it is signed out until: ______
- [ ] 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 is signed.

I authorize my health information described above to be released to Western Eagle County 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:

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 Western Eagle County 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**

©2011
Physician Contact While at Visit

Last Revised: [Date]

**Purpose:** This policy is in place in the event a Community Paramedic is at a visit with a patient and a physician needs to be contacted immediately, but the ordering physician is not available.

**Procedure:** Always begin by calling the ordering physician first. If they are unavailable, proceed through the call down list in the order provided below.

1. Call the ordering physician’s on-call service
2. Call the ambulance service’s medical control at the hospital
3. Call the ambulance service’s medical director on their mobile phone
Home Safety Assessment

Last Revised: (Date)

Purpose: The home safety assessment is designed to provide a detailed walkthrough of the client’s home, identify safety hazards and make recommendations when needed.

Procedure: The paramedic will look at many factors that have been shown to cause injuries to members of the home, especially the very young and elderly. With a specially designed checklist, (Attachment A) the assessment begins at the driveway or walkway and ends at the back yard. Note, this assessment is not a mechanical inspection of the home and is not designed to look at the safety of electrical wiring, hot water heaters, plumbing or any other mechanical features of the house. Rather, it is designed to focus on things such as trip hazards, kitchen safety, adequate lighting in the home and in walk areas, grab bars and lift handles if applicable, and other notable safety features.

A Community Paramedic does not perform the role of a physical therapist and will therefore not be analyzing the persons gait or movement, nor advising about exercises or physical therapy. If a Community Paramedic notices the client is having difficulty moving around, they should make the necessary referrals to organizations that can provide walkers, canes and other mobility devices, and also link them with their primary care physician, so that they can be referred to a physical therapist. If hazards are found, the paramedic will recommend changes that need to be made and, if needed, refer the client to the appropriate community resources that can then provide further assistance.
Western Eagle County Health Services District
Home Safety Assessment Checklist

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 ___
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.
Social Support Evaluation

Last Revised: [Date]

Purpose: The social evaluation procedure is designed for use during the home visit for the Community Paramedic to determine whether the client has the social supports necessary to help maintain their health.

Procedure: The Community Paramedic will use history taking and other interview techniques to assess the client's general well being in the home, and make sure that this is a person who has all of their basic needs met. The Community Paramedic will assess such necessities as adequate food, cleanliness, clothing, shelter, companionship, supportive social network, ability to obtain prescription medications (financially and physically in terms of being able to retrieve/open them), and other important day-to-day needs. Referrals will be made to the appropriate agencies when appropriate, and a detailed report will be given to the physician after the Community Paramedic visit.
Wound Check/Dressing Change

Last Revised: (Date)

Purpose: To perform an evaluation of a wound and to assist the patient and family caregivers in the changing of basic dressings in the home setting.

Procedure: In caring for a patient who has a wound that needs to be evaluated and have a dressing changed, the Community Paramedic will perform a history, physical, and basic evaluation of the wound to make sure that there is no infection or other obvious signs of immediate need for physician evaluation. Basic dressing changes will be performed, however, there will be no advanced care of the wound such as draining or debriding. If during the visit it appears that the wound needs any type of advanced care, the Community Paramedic will contact the physician’s office and recommend that the patient be seen as soon as possible.

Medication Compliance and Reconciliation

Last Revision: (Date)

Purpose: The purpose of this service is to evaluate the patient’s medications to determine whether they are taking and storing them correctly. Elderly patients in particular may be on multiple medications, which can create confusion. The CP will evaluate whether the patient is taking each one of their prescribed medications, at the appropriate time and correct dosage, and whether they are safely and properly storing them. The goal for the Community Paramedic is to help the client organize and correctly understand how and when to take their medications.

Procedure: Before visiting with the patient, the physician’s office will fax a copy of the most current medication list, history and orders to the Community Paramedic office so that the visiting paramedic knows exactly what plan the patient is supposed to be on. Through inspection of the medications, organizational containers and interview techniques, the paramedic will determine if the patient is following their prescribed medications and routine. If, during the visit, the paramedic finds that there is a discrepancy in how the patient is handling their medications, the physician will be contacted and discussions will be made on how to correct the problem. The paramedic will NOT change any medications, dose, or advise the patient on how to resume a normal schedule once the patient has gone off their prescribed meds or routine. The physician will make any and all decisions regarding the patient’s medications, and the paramedic is in an assistance role only.
# Community Paramedic Patient Order Form

## PATIENT INFORMATION

(May submit patient face sheet for demographics)

<table>
<thead>
<tr>
<th>Date of Order:</th>
<th>Requested Date of Service:</th>
<th>Primary Language:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Last</th>
<th>First</th>
<th>Middle</th>
<th>DOB:</th>
<th>Gender:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>M</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Street Address</th>
<th>City/Town</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mailing Address (if different):</th>
<th>City/Town</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

Insurance (for research purposes only): [ ] No [ ] Yes [ ] If yes, company:

## DIAGNOSIS

<table>
<thead>
<tr>
<th>Diagnosis:</th>
<th>Reason for Visit:</th>
</tr>
</thead>
</table>

## PREVENTION ASSESSMENTS

<table>
<thead>
<tr>
<th>Nutrition Assessment</th>
<th>Social Evaluation / Social Support</th>
<th>Home Safety Inspection</th>
</tr>
</thead>
</table>

## LABORATORY SPECIMEN COLLECTION

<table>
<thead>
<tr>
<th>□ Blood Draw</th>
<th>□ iStat Test (Coming Soon!)</th>
<th>□ Stool Collection</th>
<th>□ Urine Collection</th>
</tr>
</thead>
</table>

Requested Labs/Blood Tubes:

## CLINICAL CARE

### Cardiovascular

<table>
<thead>
<tr>
<th>□ Blood Pressure Check</th>
<th>□ EKG 12 Lead</th>
<th>□ Peripheral Intravenous Lines</th>
</tr>
</thead>
</table>

Follow-up/Post Discharge

<table>
<thead>
<tr>
<th>□ Diabetic Follow-up/Education</th>
<th>□ Neurological Assessment</th>
<th>□ Dressing Change/Wound Check/Type:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Discharge Follow-up/Diagnosis:</th>
<th></th>
</tr>
</thead>
</table>

Other Orders/Information:

### Respiratory

<table>
<thead>
<tr>
<th>□ Asthma Meds/Education/Compliance</th>
<th>□ CPAP</th>
<th>□ MDI Use</th>
</tr>
</thead>
</table>

Follow-up/Post Discharge

<table>
<thead>
<tr>
<th>□ Nebulizer Usage/Compliance</th>
<th>□ Peak Flow Meter Education/Usage</th>
<th>□ Oxygen Saturation Check</th>
</tr>
</thead>
</table>

### General

<table>
<thead>
<tr>
<th>□ Assessment / H&amp;P</th>
<th>□ Ear exams</th>
<th>□ Medication Evaluation or Medication Compliance</th>
</tr>
</thead>
</table>

Follow-up/Post Discharge

<table>
<thead>
<tr>
<th>□ Post Injury/Illness Evaluation</th>
<th>□ Post Stroke Assessment/Follow-up</th>
<th>□ Weight Check</th>
</tr>
</thead>
</table>

Other Orders/Information:

### PUBLIC HEALTH/SOCIAL SERVICES

<table>
<thead>
<tr>
<th>□ Bright Beginnings</th>
<th>□ EHS Post Partum Visit</th>
<th>□ Fluoride Varnish Clinic</th>
<th>□ Welfare Check</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>□ Disease Investigation</th>
<th>□ IZ Clinic Coverage</th>
<th>□ TB Meds DOT</th>
</tr>
</thead>
</table>

## ORDERING PHYSICIAN SIGNATURE (MUST BE SIGNED)

Contact Number: __________________________

Referring Physician: __________________________

(Please Print)

Signature: __________________________

Date: __________________________

Fax report back to referring physician

Fax report to: __________________________

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.