N. MOBILE INTEGRATED COMMUNITY HEALTH PROGRAM

1. PURPOSE

The purpose of this pilot protocol is to establish guidelines for the Mobile Integrated Community Health Pilot Program (MICHPP). The MICHPP is part of a jurisdictional/commercial or regional oversight committee. The oversight committee has, at a minimum, representatives from a Jurisdictional/Commercial EMS Operational Program (EMS Medical Director and EMS Operations), local health department, and local/regional hospital system(s). The EMSOP oversight committee must conduct a community gap/needs assessment to identify frequent utilizers of 9-1-1 services.

This program is established to identify individuals who frequently utilize 9-1-1 for non–life-threatening or medical reasons, and to assist in linking them with community resources and unexplored medical/social programs that will most appropriately meet their needs. The MICHPP team consists of a nurse practitioner/registered nurse and experienced paramedic. The uniformed MICHPP paramedic may perform an abuse/neglect evaluation, conduct a home safety check, perform vital sign acquisition (i.e., temperature, pulse, RR, BP, pulse oximetry) for the nurse practitioner/registered nurse (NP/RN), and document findings jointly with the NP/RN. The NP/RN will perform the individual assessment, medication reconciliation/compliance, make referrals, interface with the primary health care professional/physician, and make recommendations to the patient.

2. INDICATIONS

Individuals who may qualify for a home visit by the MICHPP team include:

a) Patients who have called 9-1-1 for any medically-related reason five times in any six-month interval (individual's consent required) or
b) Patients who are referred to the MICHPP by other allied health professionals or EMS clinicians (individual's consent required)

3. PRECAUTIONS

Upon initiation of the home visit, if any individual were to exhibit any signs or symptoms that would require transport to an emergency department, the MICHPP team will contact the county dispatch center who will be directed to generate an emergent response for that individual.

The MICHPP paramedic will perform all assessments and care based on current *Maryland Medical Protocols for Emergency Medical Services* until the appropriate EMS resource's arrival; care may then be transferred to that EMS unit. The NP/RN cannot direct the paramedic to perform any skill or medical intervention that is not within his or her scope of practice nor provide "Medical Consultation" as referenced in *The Maryland Medical Protocols for Emergency Medical Services*.

4. CONTRAINDICATIONS

Individuals who will not qualify for this program include:

a) Individuals already receiving care from a patient-centered medical home (PCMH) or who have already established individual home health care or use a visiting nurse agency

b) Individuals who refuse participation by revoking written consent, verbal refusal of care at time of visit, or integration into programs as in 4. a) above
c) Patients who have not reached their 18th birthday

5. PROCEDURE

After an individual has consented to be included in this program, a scheduled home visit will be performed as follows:

a) Uniformed paramedic will:
   (1) Provide a recognized uniformed presence for individual reassurance and familiarity.
   (2) Assess the individual's home.
      (a) Assess for signs of neglect or abuse.
      (b) Assess for safety issues (e.g., slip/fall risk, smoke detector, fire, exposed electrical).
   (3) Obtain basic vital signs.
      (a) Heart rate
      (b) Blood pressure
      (c) Pulse oximetry
      (d) Respiratory quality and rate
      (e) Temperature
      (f) Weight

PARAMEDIC WILL NOT BE PERFORMING BLOOD DRAWS (WITH THE EXCEPTION OF BLOOD GLUCOSE), MEDICATION ADMINISTRATION, OR ALS INTERVENTIONS UNLESS AN IMMEDIATE LIFE-THREATENING CONDITION HAS BEEN IDENTIFIED AND THE 9-1-1 CENTER HAS BEEN NOTIFIED AND AN EMS RESPONSE INITIATED.

b) NP/RN will
   (1) Evaluate for any immediate life-threatening condition.
   (2) Assess for signs of neglect or abuse.
   (3) Review vital signs.
   (4) Obtain and review the individual's past medical history.
   (5) Determine the individual's family and social history.
   (6) Review medication.
   (7) Review behavioral health.
   (8) Conduct a basic physical assessment including a focused review of systems.
   (9) Make appropriate health professional contacts, medication modifications education, and referrals

6. MEDICAL CONSULTATION as defined in *The Maryland Medical Protocols for Emergency Medical Services*

a) Obtained through jurisdictional/commercial EMS medical director or designated base station
b) Paramedics cannot accept orders from primary care physicians on the phone or on-scene unless individual has an immediate life-threatening condition and the physician is going to the hospital with individual on EMS unit.

7. DOCUMENTATION AND DATA COLLECTION

a) All data (by paramedic/NP/RN) will be collected in a patient care record that will have a data set that will meet the required QA/QI performance measure of section 8 of this Protocol.

b) The MICH program will establish policies and procedures for sharing of protected health information across allied health, social services, and community organizations, with resources available for patients.

c) In the event that an immediate life-threatening condition is identified and the MICHPP Paramedic initiated EMS care:

(1) The MICHPP paramedic shall complete an entire eMEDS® report (or Commercial EMSOP equivalent) documenting care provided.

(2) The NP/RN will complete the MICH patient care report documenting the activation of an EMS response due to immediate life-threatening condition and NP/RN individual care provided.

8. QUALITY ASSURANCE/QUALITY IMPROVEMENT

a) All calls will be reviewed by an EMSOP QA Committee consisting of Nursing, EMS, Administrative, and EMS Medical Director.

b) Data reports will be generated monthly (for the first year, and then quarterly) to the Office of the State EMS Medical Director and to the Oversight Committee.

c) The MICH metrics for reporting are as follows:

(1) The number of patients that qualified, and the number that have consented and enrolled in the MICHPP and the number that refused (ideally with the reason for refusal)

(2) The number and frequency of EMS transports and encounters for the recruited MICH patients (trending the access of health care services) for both pre- and post- enrollment of the patient into the MICHPP

(3) Aggregate summary of patient satisfaction survey (completed upon conclusion of each visit)

(4) Patient Quality of Life survey scores for both pre- and post- enrollment of the patient into the MICHPP (CDC HRQOL– 4, below)

(5) Any problems identified in complying with or applying the pilot program by the NP, RN, or Paramedic

(6) Any untoward events or formal patient complaints with detailed explanation

(7) Any increase of the number and percent of patients utilizing a primary care clinician (PCP) (if none upon enrollment)

(8) Number of referrals to additional allied health, social services, or programs that the MICHPP determines as beneficial per patient and recruited patient compliance

(9) Number and percent of medication inventories conducted with issues identified and communicated to PCP

(10) Monthly run chart reporting and/or pre-post emergency department intervention comparison

(11) Where possible, cost expenditures and cost savings (part of quarterly and annual reporting)

(12) Number and percent of safety-related interventions (physical environment assessment tool and Hendrich fall risk assessment tool)

Healthy Days Core Module (CDC HRQOL– 4)
(The numbers behind answers are for coding purposes.)

1. Would you say that in general your health is:

Please Read

a. Excellent	1
b. Very good	2
c. Good	3
d. Fair or	4
e. Poor	5
Do not read these responses	
Don't know/Not sure	7
Refused	9

2. Now thinking about your physical health, which includes physical illnes and injury, for how many days during the past 30 days was your physical health not good?

a. Number of Days	– –
b. None	88
Don't know/Not sure	77
Refused	99

3. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?

a. Number of Days	– –
b. None	88 (If both Q2 and Q3 = "None," skip next question)
Don't know/Not sure	77
Refused	99

4. During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

a. Number of Days	– –
b. None	88
Don't know/Not sure	77
Refused	99

Hendrich II Fall Risk Model™			
Confusion Disorientation Impulsivity		4	
Symptomatic Depression		2	
Altered Elimination		1	
Dizziness Vertigo		1	
Male Gender		1	
Any Administered Antiepileptics		2	
Any Administered Benzodiazepines		1	
Get Up & Go Test			
Able to rise in a single movement – No loss of balance with steps		0	
Pushes up, successful in one attempt		1	
Multiple attempts, but successful		3	
Unable to rise without assistance during test (OR if a medical order states the same and/or complete bed rest is ordered) *If unable to assess, document this on the patient chart with the date and time		4	
A Score of 5 or Greater = High Risk		**Total Score**	