

Washtenaw/Livingston Medical Control Authority

Community Paramedicine Protocols

COMMUNITY PARAMEDICINE PROTOCOLS TABLE OF CONTENTS

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Acronyms:

- CPM – Community Paramedicine
- CPMP – Community Paramedicine Program
- CP – Community Paramedic
- CPU – Community Paramedic Unit

Treatment Protocols-drafts needed

Intoxication, Psych, Pediatric Protocols-Febrile Seizure, Wound Care, Medication Reconciliation, Tooth Pain

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COMMUNITY PARAMEDICINE PROGRAM POLICY

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Community Paramedicine (CPM) Program Policy

This Community Paramedicine Program (CPMP) Policy is designed to provide alternatives to traditional treatment and transport of EMS patients. It applies to patients referred to specially trained EMS providers whose responsibility it is to evaluate and facilitate treatments and continuity plans for these patients. Treatment goals may vary depending on referral source. This protocol provides for development of a variety of programs conducted under the Community Paramedicine Program umbrella.

I Program Policy

- A. Each CPMP must have a CPP medical director appointed by the EMS Medical Director (see CPMP Medical Director Roles/Responsibilities Protocol).
- B. CPU Supervisor
 - 1. Each participating service will have a designated CPU Supervisor.
 - 2. CPU trained EMT-P with two years full time MICU experience or other qualifications as approved by the EMS Medical Director.
 - 3. CPMP Medical Director must approve the selection of the CPU Supervisor
- C. CP Course Coordinator
 - 1. The CP Course Coordinator provides initial training. Training may also be accomplished through an MCA approved CP training program.
 - 2. Licensed paramedic instructor-coordinator or qualifications as approved by the CPMP Medical Director and CPU Supervisor.
 - 3. Approved by the CPMP Medical Director and CPU Supervisor.
- D. CPU Paramedic
 - 1. Paramedic currently licensed by the MDCH.
 - 2. Employed by an approved ALS provider.
 - 3. Successfully completed an approved CP training program.
 - 4. Participated in CPM continuing education and recertification as required by the CPMP Medical Director.
 - 5. Cleared CPU Paramedic is known as a Community Paramedic (CP).

II Agency Requirements

- A. CPU Supervisor, CPMP Medical Director, CP Course Coordinator or equivalent, CPU equipment and CPU personnel are to be provided for and maintained by the agency.
- B. Provide staffing as follows:
 - 1. A Community Paramedic Unit (CPU) will be staffed with a minimum of one Community Paramedic (CP).
- C. Maintain accurate records of personnel licensure, CP training and clearance status including completion of an MCA approved clinical orientation.
- D. Records must be available to the MCB, MDCH or other appropriate regulatory agencies upon request.

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- E. Provide reports as deemed necessary by MCB and/or the EMS Medical Director, provide EPCR access to the EMS Medical Director for all reports. Provide the same for the CPMP Medical Director.
- F. All CPU personnel are expected to follow the procedures and protocols as stated in the policy. If the CPMP Medical Director, EMS Medical Director or MCB determine that the provider is in violation of the policy, the provider's or agency's CPMP approval may be suspended or revoked.

III Equipment

- A. See CPU Equipment List
- B. CPU Medication Box will be exchanged per CPU Medication Box Exchange Procedure.
- C. Standard ALS Equipment

IV CP Training Program

- A. Program Faculty
 - 1. CPU Supervisor
 - a. Responsible for supervision of all aspects of the CPMP program.
 - b. Participates in selection, training and certification process for CPs.
 - c. Supervises and assures that education and proficiency requirements are met.
 - d. In conjunction with the CPMP provider agency, provides data to CPMP medical director and MCA as required.
 - 2. CP Course Coordinator – responsible for coordination and instruction of the CP training program.
- B. Student Qualifications
 - 1. Fully licensed paramedic by MDCH – EMS Division and employed by an approved ALS provider.
 - 2. Two years of experience as a paramedic and approval of the sponsoring agency.
- C. CPP Initial Training Course and approval process
 - 1. Approved by CPMP Medical Director and the EMS Medical Director.
 - 2. See CP Curriculum.
- D. Provisional Community Paramedic Approval
 - 1. Successful completion of CP initial training course.
 - 2. Successful completion of CP test.
- E. Community Paramedic Approval
 - 1. Complete CPU Orientation Checklist.
 - 2. Complete CPU clinical experience.
 - 3. Approval of the CPMP Medical Director and CPU Supervisor.
- F. Recertification
 - 1. In order to maintain clearance as a CP, personnel must staff the CPU on a regular basis. If there has been a significant lapse in an individual's CPU experience they may be reclassified as a provisional Community Paramedic

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until approved for Community Paramedic status by the CPU Supervisor and CPMP Medical Director. Maintain MCA-required training competencies.

V CPU Reporting

- A. Each CPU patient contact will be documented on an MCA designated CPU EPCR.
- B. EPCR access will be provided for the CPU Supervisor, CPMP Medical Director or EMS Medical Director for review as requested.

VI CPU Procedures

- A. See CPU Treatment Capabilities for patients appropriate for CPU referral. Patients not meeting these indications should be initially evaluated by ALS personnel. After initial evaluation, patients may be transported or referred for CPU continued care as determined under these protocols and as approved by the CPMP Medical Director and the EMS Medical Director.
- B. Patient Treatment
 - 1. Initial patient treatment is defined under these protocols and standard EMS treatment protocols.
 - 2. CPU personnel will use CPMP treatment protocols and standard EMS treatment protocols during the evaluation and treatment of CPU patients. Contact the CPMP Medical Director or on-line medical direction for any problems.

VII Continuity

- A. Each patient evaluated and treated under the Community Paramedicine Program must have a continuity plan at the end of evaluation and treatment. This plan may include: transport to an ED or other designated facility, arranged follow up with a primary care provider or designated clinic or facility or other plan as approved by the CPMP Medical Director.

VIII Follow Up and Program Reporting

- A. Each patient evaluated and treated under the Community Paramedicine Program should be contacted after treatment at a time as determined by the CPMP Medical Director. Information obtained and outcomes collected should include: Success of continuity plan (was it completed or not, if not what was done?), tabulation of various categories of treatment plans and patient satisfaction with the evaluation, treatment and continuity plan.
- B. The above information will be provided on a semi-annual basis to the EMS Medical Director, the MCB and MDCH as requested.

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CPU TREATMENT CAPABILITIES

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Community Paramedic Unit Treatment Capabilities

The Community Paramedic Unit (CPU) has treatment capabilities designed to meet your patient's episodic and non-emergent patient evaluation and treatment needs. The CPMP staff has been trained to evaluate, treat and facilitate continued of care for stable patients. Patient treatment is provided through State of Michigan approved protocols and 24-hour on call physician medical direction.

If the patient's stability allows and treatment and continuity options are available as covered by the CPU protocols, the CPU will evaluate and treat referred patients. If the patient is outside of these criteria or is deemed to not have sufficient stability for CPU evaluation and treatment the CPU staff will either arrange transport of the patient as indicated or contact the CPMP on-call physician to determine the most appropriate patient disposition.

MEDICATIONS

Medications available to the CPU include those covered by standard EMS protocols and those carried in the CPU Medication Pack: See CPU Medication Pack Contents, Exchange Procedure and Use/Replacement List

CPU PROGRAMS

911 Call Triage – Low acuity 911 patients may be referred to specially trained call center personnel who helps the patient find appropriate resources for their medical issue. Patients may be evaluated by CPU personnel in order to help develop continuity plans and teach the patients to manage their health care needs.

Frequent EMS User Management – Patients who use 911 frequently may be referred to program case managers for enrollment. Patients may be evaluated by CPU personnel in order to help develop continuity plans and teach the patients to manage their health care needs.

Post Acute Care Transition – Patients at risk for hospital readmission after hospital discharge may be referred to the CPMP by the patient's physician or case manager. The CPU may make a series of home visits educate the patient and family on appropriate care management and provide a continuity plan. The CPU may provide home treatment designed to reduce the need for hospital readmission. Conditions treated may include CHF, Asthma, COPD and other conditions as designed by the CPMP Medical Director.

After Hours Episodic Care – Patients may be referred to the CPMP for after hours episodic care management. In combination with 911 Call Triage, the CPU may respond for patient evaluation, treatment and continuity planning.

Hospice Patient Evaluation and Treatment – Hospice patients may be referred to the CPMP for episodic care management with the goal of reducing hospitalizations. In combination with 911 Call Triage or direct call triage, the CPU may respond for patient evaluation, treatment and continuity planning.

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Extended Care Facility Episodic Care – Patients may be referred to the CPMP through agreement with the facility or referral by the patient’s physician. In combination with 911 Call Triage or direct call triage, the CPU may respond for patient evaluation, treatment and continuity planning.
EMS Patient Management – EMS patients determined to be candidates for CPU evaluation and treatment may be referred to the CPMP by the EMS unit with agreement of the patient. The CPU may respond for patient evaluation, treatment and continuity planning.
Incapacitated Patient Assessment – EMS patients determined to be compromised by Alcohol or Mental Health issues may have a CPU response for patient evaluation, treatment and continuity planning.
Home Safety Assessment – CPU may perform home safety assessments as part of any home visit with recommendation made to the patient and primary care provider.
Other Programs - Other patient care programs may be developed and implemented as needed by the community under the direction of the EMS Medical Director and designated CPMP Medical Director.
The following procedures are covered by standard protocols and are pre-approved for use by the CPU: Foley catheter placement, IV starts, Feeding tube maintenance and replacement facilitation and wound care evaluation and treatment.
<u>PATIENT CONDITION AND STABILITY</u>
The patient must be hemodynamically stable for CPU evaluation and treatment.

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CPMP MEDICAL DIRECTOR ROLE AND RESPONSIBILITIES

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CPMP Medical Director Role/Responsibilities

The CPMP Medical Director (CPMP-MD) will be a physician appointed by the Washtenaw/Livingston County EMS Medical Director with approval of the Medical Control Board. The CPMP-MD will be a physician actively practicing in Washtenaw or Livingston County. The CPMP-MD will be responsible for oversight of the medical operations of the CPU and will provide:

1. The CPMP-MD will provide for 24 hour physician availability for CPU consultation. This may be done with one or multiple designated physicians. Patient treatment and disposition consultation provided through on-line medical direction are included in the responsibilities of the CPMP-MD.
2. Review of all CPU runs providing feedback to the CPU personnel regarding appropriate evaluation, treatment and continuity planning performed during the CPU patient interaction.
3. Oversight of new CPU personnel training, curriculum, and credentialing of CPU personnel for CPU practice.
4. Oversight of CPU continuing education which will include didactic, practical and patient interaction review formats.
5. Periodic CPMP reports to the Medical Control Board.
6. Remediation of CPU personnel, if necessary.
7. Oversight of development of CPMP treatment protocols.
8. Oversight of development of procedures for expanding CPU scope of practice.

The CPMP-MD will be appointed for a one year term to be renewed at the discretion of the Medical Control Board and the CPMP agency provider. This appointment will have a calendar year term.

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CCPU REQUIRED EQUIPMENT LIST

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Community Care Paramedic Unit (CCPU) Required Equipment List

Equipment

The CCPU must carry the following equipment:

- 1) Pulse oximeter
- 2) Blood pressure/pulse monitor
- 3) Cellular telephone
- 4) Glucometer
- 5) A CCPU Medication Box
- 6) Foley catheters of various sizes
- 7) Wound care equipment (see Wound Care Protocol)
- 8) I-STAT blood analyzer
- 9) Monitor/defibrillator with pacing and 12-lead ECG capability
- 10) A standard ALS medication box
- 11) Alcohol breathalyzer
- 12) Bathroom scale
- 13) Infant scale
- 14) Oral/Rectal Thermometer
- 15) CCPU Medication box

Each CCPU Medication Box will be used as defined in CPP Treatment Protocols needed for patient treatment and will be exchanged at the Hospital pharmacy per the CCPU Medication Pack Contents, Exchange Procedure and Use/Replacement List Protocol.

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Community Paramedicine Protocols
CPU MEDICATION BOX CONTENTS, EXCHANGE PROCEDURE & USE
REPLACEMENT FORM

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CPU Medication Box Contents, Exchange Procedure & Use Replacement Form

1. The cooperating hospital's pharmacy shall accept the responsibility for permanent inventory reconciliation of a specific number of CPU medication boxes. It is the responsibility of the hospital pharmacy to develop and implement appropriate record keeping and security measures in accordance with Title 21, Federal Controlled Substances Act, which will minimize the potential for diversion.
2. The cooperating hospital pharmacy will stock the CPU medication boxes in accordance with the medication list approved by the CPMP Medical Director and the Washtenaw/Livingston County Medical Control Authority.

Procedure:

- A. The medications placed in the boxes shall be consistent throughout the stock of CPU medication boxes as to dosages and concentrations prescribed by the CPU Medication Box Replacement Form.
- B. Labels shall be securely attached to the outside of all medication boxes which shall include:
 1. The name of the hospital pharmacy which last restocked the box.
 2. The date the box was last restocked.
 3. The legible initials of the pharmacist who inventoried and restocked the medication box.
 4. The earliest date at which any medication or solution in the box would expire (30 day lead time recommended).
- C. After the medication box has been inventoried, restocked, and appropriately labeled, the pharmacist will attach a green plastic breakaway seal. A red seal will be placed in the box by the restocking pharmacy for use by the Community Paramedic. The hospital pharmacy will be solely responsible for dispensing and accounting for these seals.
- D. The sealed medication boxes will be placed in a locked storage area in the participating hospital pharmacy or appropriate location designated by the participating hospital pharmacy. Only staff designated by the participating hospital pharmacy will have access to the medication boxes. A permanent record shall be maintained indicating the number on the medication box, the CPU designation, the name of the Community Paramedic to whom the medication box was issued, and the name of the pharmacy designated staff or pharmacist receiving or dispensing the box. Other facilities may provide a similar service as approved by the MCA.
- E. The CPU run record shall serve as a permanent medical record of physician orders for medications administered.

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CPU MEDICATION BOX CONTENTS, EXCHANGE PROCEDURE & USE
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- F. When medications from the box are used or whenever the pharmacy seal on the box is broken, the Community Paramedic will place a copy of the Washtenaw/Livingston MCA CPU Medication Box Replacement Form, including patient name and registration number, signed by the physician/nurse, in the medication box. The Community Paramedic will then reseal the medication box utilizing the red seal that the pharmacist placed in the medication box for that purpose.
 - G. The used CPU medication box will then be exchanged for a pharmacy-sealed box at the SJMH pharmacy designated area under the supervision of the appropriate pharmacy staff. Once sealed by the pharmacist, the exchanged box will not be inventoried by the Community Paramedic personnel prior to documented necessity for use.
 - H. All requirements for signatures and filing of the CPU run report apply independent of the receiving facility whenever a CPU medication box is used for patient transport.
 - I. Any discrepancies in the medication box will be documented on ALS Medication Discrepancy Report and clearly labeled CPU Medication Box Discrepancy form.
 - 1. If the discrepancy is discovered by the Community Paramedic at the time of utilization, the report form shall be signed by the Community Paramedic.
 - 2. Hospital pharmacists who note discrepancies in the medication box inventory, which cannot be accounted for by the CPU run records, shall initiate and sign the discrepancy form.
 - 3. Copies of the discrepancy reports, along with copies of the CPU run report, are sent to the CPMP Medical Director and the ambulance service that is responsible for evaluation and follow up and will retain the records for one year. The original is retained by the hospital pharmacy.
 - 4. Controlled substances which are contaminated, lost through spillage, or partially used must be accounted for on the CPU run record by the Community Paramedic.
 - J. Locked and secure compartments or other locking devices approved by the Michigan Department of Health and Human Services shall be provided on the CPU vehicle and utilized to prevent access to stored drugs by unauthorized persons.
 - K. Any incident resulting in diversion of a controlled substance shall be promptly reported by the Participating Hospital pharmacy. The report of the circumstances concerning the diversion shall be forwarded to the following:
 - 1. Board of Pharmacy
 - 2. Michigan Department of Health and Human Services
 - 3. The local law enforcement agency.
 - 4. U.S. Department of Justice/Drug Enforcement Administration (Report to DEA must be submitted on DEA Form 106 "Report of Theft or Loss of Controlled Substances").
 - 5. CPMP Medical Director
 - 6. EMS Medical Director

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CPU MEDICATION BOX CONTENTS, EXCHANGE PROCEDURE & USE
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Washtenaw/Livingston MCA - CPU Medication Box Replacement Form

AGENCY/UNIT _____ HOSPITAL _____

DATE _____ INCIDENT # _____

EMS CREW (NAMES) _____

Medication	Unit/Size	Quantity	Used
amoxicillin/clavulanate 500 mg/125 mg	Tab/Capsule	1	
trimethoprim/sulfamethoxazole DS (Bactrim) 160 mg/800 mg	Tab	1	
clindamycin (Cleocin) 150 mg	Tab/capsule	2	
cephalexin (Keflex) 500mg	Tab/capsule	1	
ciprofloxacin (Cipro) 500 mg	Tab	1	
diphenhydramine (Benadryl) 25 mg	Tab/Capsule	2	
phenazopyridine (Pyridium) 95 mg	Tab	2	
azithromycin (Zithromax) 250 mg	Tab	2	
penicillin V potassium 500 mg	Tab/capsule	1	
furosemide (Lasix) 40 mg	Tab	3	
oxymetazoline (Afrin) 0.05%	15 mL bottle	1	
potassium chloride (K-lor) 20 mEq	Powder packet	2	
meclizine (Antivert) 25 mg	Tab	1	
ondansetron (Zofran ODT) 4 mg	ODT	2	
acetaminophen (Tylenol) 325 mg	Tab	2	
ibuprophen (Motrin) 200 mg	Tab	4	
acetaminophen (Tylenol) oral suspension 650mg/20.3 ml	Unit Dose 30 mL	1	
ibuprofen (Motrin) oral suspension 100 mg/ 5 mL	Unit Dose 10 mL	2	
Oral Syringe	20 mL	2	

Patient Name: _____

Registration Number: _____

Address: _____

City/State/Zip: _____

Paramedic Statement

CPU Medication Box Number _____ has been opened and the above noted medication(s) used as prescribed. This box has been red sealed with breakaway tag number _____.

Community Paramedic Signature: _____ Date: _____

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Community Paramedicine Protocols
COMMUNITY PARAMEDIC TRAINING PROGRAM

Date: March 2015

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Community Paramedic Training Program

Training Program Components

A. Classroom Training - The Community Paramedic (CP) training course (Appendix 1 – Training Curriculum) was developed to provide the CP with training in the following areas:

1. **Expanded Patient Assessment** – The Community Paramedic Unit (CPU) responders may assess the patient in a number of areas including: well person check i.e. immunizations, BP, Cholesterol, BMI, diabetes screening, and home safety evaluation including medication compliance.
2. **Identify Chronic Debilitative Diseases** – The CP will identify components of chronic disease including: pathophysiology, assessment interim treatment including: COPD/Asthma, CHF, Diabetes/Blood sugar, hypertension, kidney disease/dialysis, neuropathy, Alzheimer's/dementia, decubitus ulceration and skin assessment/foot & wound care).
3. **Post-Operative Assessment** – The CP will provide post-operative patient assessments for CABG and other conditions. Follow up and assessment may include 12 lead, lung sounds, BP, edema assessment, medication & weight compliance.
4. **Care and Support of Hospice/Terminally Ill Patients** – Assessment and treatment of these patients.
5. **Homebound patients with Special Challenges** – Assessment and treatment of patients with challenges related to decreased mobility and inability to get to medical care. Treatments may include: assessment and reinsertion of G-Tubes, Foley catheters, recognition and treatment of UTI's including sepsis.
6. **Assessment of the Psychiatric/Behavioral Health** – Assessment and treatment of patients with conditions including chronic psychiatric/emotional disorders, acute alcohol withdrawal and depression questionnaire.
7. **Assess and Treat of Patients with Non-emergent Complaints Without Priority Symptoms** – Symptom and condition evaluation including: nausea and vomiting, upper respiratory infection, tooth pain, kidney stones, febrile seizures and abdominal pain.
8. **Medication Familiarity** – Recognize commonly prescribed medications, understand how to assess and access their indications, side effects and interactions with other common medications.

B. **Clinical Experience**

1. Emergency Department - Emphasis on chronic care patients.
2. ICU - Emphasis on labs, disease process, recovery and discharge.
3. Hospice - Emphasis on end of life issues including family needs.

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4. Home/Wound care - Emphasis on decubitus ulceration, skin assessment and home care.
 5. Dialysis center - Emphasis on CV complications based on electrolyte imbalance, access sites and complications/infections.
 6. Nephrology care - Emphasis on disease process and end stage renal disease.
 7. Access center - Emphasis on central lines and access ports.

Training will be taught by paramedic instructors, clinical care nurses, specialty care nurses as well as physicians with an expertise in those areas. Clinical time will be done in conjunction with our participating teaching facilities. The curriculum will be reviewed and approved by the CPMP Medical Director and the Medical Control Board.

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Appendix 1 – Training Curriculum
A. Classroom Training

Class	Topic	Study-Exam-Lab Skills	Lecture	Lab
1	Course Introduction & overview Mobile Integrated healthcare CCP State study, jurisdiction, role Established programs Demographics of chronic disease		4	
2	Expanded scope of practice General concepts of disease and diagnosis		4	
3	A&P review Pathophysiology of disease		4	
4	A&P review Pathophysiology of disease		4	
5	Expanded Patient assessment Differential diagnosis	Comprehensive physical assessment Documentation	2	2
6	Expanded Patient assessment Differential diagnosis	Comprehensive physical assessment Documentation	2	2
7	Factors influencing CV disease and debilitating conditions		4	
8	Factors influencing CV disease and debilitating conditions Primary/secondary hypertension		4	
9	Respiratory disease/pathogenesis of obstructive pulmonary disease		4	
10	Bronchiectstasis / Pneumonia Severe acute respiratory syndrome (SARS) / Bronchial asthma	Spirometry testing	3	1
11	Diabetes Mellitus & associated chronic complications		4	
12	Diabetes treatment and control Types of insulin/Lantus Oral meds		4	

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Class	Topic	Study-Exam-Lab Skills	Lecture	Lab
13	Diabetic wound care and ulcerations Diabetic neuropathy – foot care Educating the patient	Identify stages of decubitus ulcerations Wound care techniques		4
14	Urinary system and secondary complications Diabetic nephropathy Urinary tract infections (UTI)	Urine dipstick testing Lactate testing	2	2
15	Chronic nervous system diseases & conditions – Alzheimer – dementia Memory testing Febrile seizures	Memory testing Home safety assessment & Activities of daily living (ADL)	2	2
16	Hospice and terminally ill patients Assessment and intervention Social worker intervention criteria	Breathalyzer testing	4	
17	Gastrointestinal disease and chronic debilitating conditions GERD/IBS, Hemorrhoids Antibiotic associated colitis Vomiting/diarrhea management		4	
18	Homebound patient with special needs; G-J Tubes, Foley Reinsertion Central /PICC lines/Implanted ports	Foley catheter G-J tube trainer		4
19	Geriatric Care/Safety inspections Dental care – tooth pain Education for pts with A-fib / valvular disease	Antibiotic, NSAID Benzocaine spray	4	
20	Lab draws (Phlebotomy) on scene Strep screens Wound cultures Blood chemistry	I-Stat Chem 7 & 8 test Strep A test strips		2
21	Immunizations schedule/education and administration of boosters	Adult schedule Td/Tdap, Influenza, Pneumonia Zoster, Hep A/B series	4	

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Class	Topic	Study-Exam-Lab Skills	Lecture	Lab
22	Written Final exam Skills Review	Foley Insertion Wound dressing Central venous Cath..dressing/flushing	2	2
<p>General Medications commonly prescribed by physicians.</p> <p>CCP's should be <u>familiar</u> with:</p> <ul style="list-style-type: none"> • General class • Indication • Dosing • Side effects • Potentiation & interaction 		<p>Narcotics Non-Steroidal anti-inflammatories Antipsychotics Antidepressants Statins Anti-hypertensives ACE inhibitor Calcium channel blocker Diuretic Beta blockers GI therapy H2 blocker Proton pump inhibitor Oral diabetic medications Sulfonylureas Injected diabetic medications Asthma/COPD Short acting beta agonist Long acting beta agonist Inhaled steroid Inhaled anticholinergics Antibiotics Sleep aids Anticoagulants Erectile dysfunction medications Benzodiazepines Seizure medications Other</p>		

- B. Clinical Experience
1. Emergency Department - 16 hrs adult and 16 hrs pediatric
 2. CCU/ICU - 16 hrs
 3. Hospice – 8 hrs
 4. Home/Wound care – 16 hrs
 5. Dialysis center – 4 hrs
 6. Nephrology care – 4 hrs
 7. Access center – 8 hrs
- C. Internship Rotations:
1. CP Unit – 24 hours

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Community Paramedicine Protocols
GENERAL PROTOCOL FOR CPU PATIENT ASSESSMENTS

Date: November 2014

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General Protocol for CPU Patient Assessments

Indications: This protocol provides general guidance for the evaluation of patients under the Community Paramedicine Program.

CPU Directives:

1. Prior to initiation of patient contact obtain dispatch and visit information to include: patient complaint/illness/reason for visit. Review any available previous pertinent patient care records.
2. The CP should introduce him/herself to the patient.
3. Assure the scene is safe for the patient and CP (not a full home safety assessment). Assure there is adequate privacy for performing a CPU patient assessment.
4. Obtain a history of patient's present illness/complaint. Sources may include the patient, 911 triage, referring physician or agency, family or referring EMS unit.
5. Perform a physical exam pertinent to the patient's complaint/condition. Exam may be focused or complete. Obtain full set of vital signs including: temperature, heart rate, blood pressure, respiratory rate and pulse ox.
6. Perform diagnostic studies as indicated for the patient illness/complaint (Accucheck, ECG, ETCO₂, I-STAT blood analysis, other studies as available).
7. If the on scene CP discovers indications of current or impending patient instability, the CP will contact on-line medical direction for consultation and/or arrange for transport to the ED or alternative treatment facility.
8. Follow appropriate CPU treatment protocol.
9. Contact designated on-line medical control physician or designee.
 - a. Provide patient report including: reason for visit/complaint/illness, physical exam, diagnostic studies and treatment performed.
 - b. Medical direction may be performed by radio/cell link or telemetric link providing real-time patient imaging.
 - c. Determine whether on-scene treatment or patient transport to an ED or alternative treatment facility is indicated.
10. If on-scene treatment is determined appropriate by the CP or on-line medical direction, continue patient treatment as indicated by CPU protocol and/or as directed by on-line medical.
11. Continue on-scene treatment until the patient is comfortable with staying in place or a transport decision has been made.
12. Develop a continuity plan which should include: medications administered, medication reconciliation, prescriptions provided, return CP visit schedule, clinic or physician follow up schedule and logistics for follow up compliance if indicated.

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ASTHMA/COPD TREATMENT & MANAGEMENT

Date: October 2014

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Asthma/COPD

Indications: This protocol provides general guidance for the evaluation of patients with Asthma under the Community Paramedicine Program. The CPU will respond to a residence on request from the primary care provider, on request by the patient/parent of patient through 911 triage or on referral from ALS 911 response. The CP will follow guidelines outlined by the primary care providers, EMS treatment protocols or on-line medical direction orders for the management of asthma/COPD.

Purpose: Assist the patient (family/caregiver) by increasing awareness of the disease through education on pathology. Demonstrate and review technique of all devices used to treat asthma to assist patient compliance. Evaluate and identify home triggers of disease in an effort to lessen exacerbations of asthma/COPD. Communicate with the primary care provider or on-line medical direction on the condition of the patient as well as on the general well-being of the patient as well as continuing medication reconciliation and continuity plan.

CPU Directives:

1. Follow **General Protocol for CPU Patient Assessments**.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. If no immediate treatment is needed, perform medication review, and patient education.
 - a. Review pathophysiology with the patient.
 - b. Record the patient's current history including frequency of symptoms with rest, activity and with sleep.
 - c. Further history will include exacerbating factors including viral exposure, allergen exposure, exercise, cold air, tobacco smoke, chemical irritants, etc.
 - d. Observe home in an effort to possibly identify exacerbating factors.
 - e. Review devices used by the patient including short/long acting medications and MDI/continuous nebulizer devices.
 - f. Review when to call health care provider.
 - g. Contact the primary care provider (PCP) to confirm the continuity plan.
4. If immediate treatment is needed follow the **Adult or Pediatric Respiratory Distress Protocol** as follows:
 - a. Administer Nebulized Bronchodilators per **Nebulized Bronchodilators Procedure**.
 - b. Administer Epinephrine 1:1,000, 0.3 mg (0.3 ml) IM in patients with impending respiratory failure unable to tolerate nebulizer therapy.
 - c. If a second nebulized treatment is needed, administer Prednisone OR Methylprednisolone if not already a part of the PCP homecare orders.
 - d. Consider CPAP/BiPAP (if available) per **CPAP/BiPAP Procedure**.

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Community Paramedicine Protocols
ASTHMA/COPD TREATMENT & MANAGEMENT

Date: October 2014

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5. Continue treatment and follow the **General Protocol for CPU Patient Assessments** until a disposition is determined and continuity plan completed. This plan may include return visits for those patients who received on-scene treatment.

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Community Paramedicine Protocols
CONGESTIVE HEART FAILURE

Date: October 2015

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Congestive Heart Failure

Indications: This protocol provides general guidance for the evaluation of patients with Congestive Heart Failure (CHF) under the Community Paramedicine Program. The CPU will respond to a residence on request from the primary care provider, on request by the patient through 911 triage or on referral from ALS 911 response. The CP will follow guidelines outlined by the primary care providers, EMS treatment protocols or on-line medical direction orders for the management of CHF.

Purpose: Assist the patient (family/caregiver) by increasing awareness of the disease through education on pathology. Monitor patient condition after hospital discharge including: patient medication compliance, patient diet and fluid intake. Monitor the patient's weight. Communicate with the primary care provider or on-line medical direction on the condition of the patient as well as on the general well-being of the patient as well as continuing medication reconciliation and continuity plan.

CPU Directives:

1. Follow **General Protocol for CPU Patient Assessments**.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. If no immediate treatment is needed, perform medication review, and patient education.
 - a. Review pathophysiology with the patient.
 - b. Record the patient's current history including: diet, fluid intake, success of diuretic treatment if ongoing.
 - c. Review devices used by the patient including: oxygen, diuretics, CPAP and other medications being used for maintenance.
 - f. Review when to call health care provider.
 - g. Contact the primary care provider (PCP) to confirm the continuity plan.
4. If immediate treatment is needed follow the **Pulmonary Edema/CHF Protocol** as follows:
 - a. Consider CPAP / Bi-PAP (if available). See **CPAP/BiPAP Administration Procedure**. The need for CPAP/BiPAP should trigger transport.
 - b. Obtain 12-lead ECG if available. Follow local MCA transport protocol if ECG is positive for ST segment elevation myocardial infarction (STEMI) and alert hospital as soon as possible.
 - c. Inquire of all patients (male and female) if they have taken Viagra (sildenafil citrate) or similar erectile dysfunction medications or medications used to treat pulmonary hypertension in the last 48 hours. If yes, do not administer nitroglycerin and contact the patient's PCP or contact on-line medical direction.

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CONGESTIVE HEART FAILURE

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- d. If BP above 100 mmHg, administer Nitroglycerin 0.4 mg SL. Repeat every 3-5 minutes if BP above 100 mmHg. Nitroglycerin may be administered prior to IV placement if the BP is above 120 mmHg.
 - e. If wheezing or bronchial constriction administer nebulized Albuterol 2.5 mg/3ml.
5. Contact the PCP or on-line medical direction per the **General Protocol for CPU Patient Assessments**. Consider administration of Furosemide 20 – 100 mg PO or IV for patients with fluid overload and insufficient diuresis on home medications. Dosage should be determined in consultation with the PCP or on-line medical direction.
6. Continue treatment and follow the **General Protocol for CPU Patient Assessments** until a disposition is determined and continuity plan completed. This plan may include return visits for those patients who received on-scene treatment.

Washtenaw/Livingston Medical Control Authority
Community Paramedicine Protocols
CPAP/BIPAP/SLEEP APNEA/ OXYGEN SAT CHECKS

Date: October 2014

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CPAP/BiPAP/Sleep Apnea/Oxygen Sat Checks

Indications: This protocol provides general guidance for the evaluation of patients with CPAP/BiPAP therapy, Sleep Apnea and those recently placed on oxygen under the Community Paramedicine Program. The CPU will respond to a residence on request from the primary care provider, on request by the patient through 911 triage or on referral from ALS 911 response. The CP will follow guidelines outlined by the primary care providers or on-line medical direction orders.

Purpose: To assist the PCP in observing and documenting recently diagnosed/chronic sufferers of obstructive sleep apnea through written and /or verbal communication to ensure proper ventilation of the patient during sleep for the purpose of avoidance of long term Obstructive Sleep Apnea pathologic outcomes.

CPU Directives:

1. Follow **General Protocol for CPU Patient Assessments**.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. If no immediate treatment is needed, perform medication review, and patient education.
 - a. Review pathophysiology with the patient.
 - b. Review devices used by the patient including: oxygen, CPAP/BiPAP devices and other medications being used for maintenance.
 - f. Review when to call health care provider.
 - g. Patient should be monitored for hemodynamic instability the first 8 hours after starting CPAP/BiPAP.
4. Conduct a patient assessment which includes:
 - a. Vital Sign assessments including PO₂ and ET_{CO}₂ and weight/BMI
 - b. Sleep habits (work nights? Irregular work schedule)
 - c. Alcohol/recreational drug use? Prescription drug use? Compliant?
 - d. Quality of life - Noticeable changes after usage.
5. Troubleshoot if necessary including ensuring proper fit of mask and use of machine as well as general condition of machine.
6. If oxygen is being used assure the patient has connection with necessary resources (oxygen supply company, etc.) to maintain continued supply.
5. Contact the PCP or on-line medical direction per the **General Protocol for CPU Patient Assessments**.
6. Continue treatment and follow the **General Protocol for CPU Patient Assessments** until a disposition is determined and continuity plan completed. This plan may include return visits for those patients in whom oxygen saturation is less than 95% on treatment after on-scene assessment and treatment.

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Community Paramedicine Protocols
URINARY COMPLAINTS

Date: October 2014

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Urinary Complaints

Indications: This protocol provides general guidance for the evaluation of patients with Urinary complaints under the Community Paramedicine Program. These complaints may include pain with urination, urinary retention and hematuria. The CPU will respond to a residence on request from the primary care provider, on request by the patient through 911 triage or on referral from ALS 911 response. The CP will follow guidelines outlined by the primary care providers or on-line medical direction orders.

Purpose: To assess complaints related to the urinary tract.

CPU Directives:

1. Follow **General Protocol for CPU Patient Assessments**.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. Obtain a urine sample for urine dip stick. The urine should be clean catch, strait catheterization for intermittent catheterization patient or current/new Foley sample as indicated.
4. Use the urine dipstick results to guide therapy:
 - a. If the urine is positive for infection consider oral and/or IV antibiotics.
 - b. If the urine is negative for infection and urinary retention is suspected consider Foley catheter insertion.
 - c. If hematuria alone is present, assess for urinary retention or kidney stone.
5. Contact the PCP or on-line medical direction per the **General Protocol for CPU Patient Assessments**. Along with the patient report, give the results of the urine dipstick and discuss treatment and continuity plan.
6. Continue treatment and follow the **General Protocol for CPU Patient Assessments** until a disposition is determined and continuity plan completed.

Washtenaw/Livingston Medical Control Authority
Community Paramedicine Protocols
HOME SAFETY ASSESSMENT

Date: October 2015

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Home Safety Assessment

Indications: This protocol provides general guidance for evaluating the safety of a patient's residence under the Community Paramedicine Program. The CPU will respond to a residence on request from the primary care provider, on request by the patient through 911 triage or on referral from ALS 911 response. The CP will follow guidelines outlined by the primary care providers, referring agency or provider.

Purpose: To ensure the home is in a safe condition in order to meet the medical needs of the patient. This protocol can be used to conduct a pre-surgical assessment, post-operative assessment, or an evaluation of the safety of the home at any time.

CPU Directives:

1. Follow **General Protocol for CPU Patient Assessments** as indicated.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. Follow the Home Safety Checklist including the inspection of the following areas of the home:
 - a. Outside of the house
 - b. Living room
 - c. Kitchen
 - d. Stairs
 - e. Bathroom
 - f. Bedroom
 - g. General Inspection
4. Complete the Home Safety Checklist
5. Complete recommendations for the resident and possible referrals
6. Discuss the findings with the patient and resources to remedy
7. Review the report with the patient to assure they understand the recommendations.
8. Complete report and return a copy to the PCP or designated provider.
9. If any life-threatening issues are identified, notify the ordering PCP or designated provider immediately.

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Community Paramedicine Protocols
HOME SAFETY ASSESSMENT

Date: October 2015

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NAME:	DATE:
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HOME SAFETY CHECKLIST

I. EXTERIOR ENTRANCES AND EXITS

- Note condition of walk and drive surface; existence of curb cuts
- Note handrail condition, right and left sides
- Note light level for driveway, walk, porch
- Check door threshold height
- Note ability to use knob, lock, key, mailbox, peephole, and package shelf
- Do door and window locks work easily?
- Are the house numbers visible from the street?
- Are bushes and shrubs trimmed to allow safe access?
- Is there a working doorbell?

Please document below any deficiencies and recommendations for safety improvement

2. INTERIOR DOORS, STAIRS, HALLS

- Note height of door threshold, knob and hinge types; clear width door opening; determine direction that door swings
- Note presence of floor level changes
- Note hall width, adequate for walker/wheelchair
- Determine stair flight run: straight or curved
- Note stair rails: condition, right and left side
- Examine stairway light level
- Note floor surface texture and contrast
- Note if clutter on stairway

Please document below any deficiencies and recommendations for safety improvement

3. BATHROOM

- Are sink basin and tub faucets, shower control and drain plugs manageable?
- Are hot water pipes covered?
- Is mirror height appropriate, sit and stand?
- Note ability reach shelf above, below sink basin
- Note ability to step in and out of the bath and shower
- Can resident use bath bench in tub or shower?
- Note toilet height; ability to reach paper; flush; come from sit to stand posture
- Is space available for caregiver to assist?

Please document below any deficiencies and recommendations for safety improvement

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Community Paramedicine Protocols
HOME SAFETY ASSESSMENT

Date: October 2015

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4. KITCHEN

- Note overall light level, task lighting
- Note sink and counter heights
- Note wall and floor storage shelf heights
- Are under sink hot water pipes covered?
- Is there under counter knee space?
- Is there a nearby surface to rest hot foods on when removed from oven?
- Note stove condition and control location (rear or front)
- Is there adequate counter space to safely prepare meals?

Please document below any deficiencies and recommendations for safety improvement

5. LIVING, DINING, BEDROOM

- Chair, sofa, bed heights allow sitting or standing?
- Do rugs have non-slip pad or rug tape?
- Chair available with arm rests?
- Able to turn on light, radio, TV, place a phone call from bed, chair, and sofa?

Please document below any deficiencies and recommendations for safety improvement

6. LAUNDRY

- Able to hand-wash and hang clothes to dry?
- Able to safely access washer/dryer?

Please document below any deficiencies and recommendations for safety improvement

7. BASEMENT

- Are the basement stairs stable and well lit?
- Is there any storage of combustible materials?

Please document below any deficiencies and recommendations for safety improvement

8. TELEPHONE AND DOOR

- Phone jack location near bed, sofa, chair?
- Able to get phone, dial, hear caller?
- Able to identify visitors, hear doorbell?
- Able to reach and empty mailbox?
- Wears neck/wrist device to obtain emergency help?
- Is there an answering machine?
- Is there a wireless phone system?

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Community Paramedicine Protocols
HOME SAFETY ASSESSMENT

Date: October 2015

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Please document below any deficiencies and recommendations for safety improvement

9. STORAGE SPACE

- Able to reach closet rods and hooks, open bureau drawers?
- Is there a light inside the closet?

Please document below any deficiencies and recommendations for safety improvement

10. WINDOWS

- Opening mechanism at 42 inches from floor?
- Lock accessible, easy to operate?
- Sill height above floor level?
- Are storm windows functional?

Please document below any deficiencies and recommendations for safety improvement

11. ELECTRIC OUTLETS AND CONTROLS

- Sufficient outlets?
- Are there ground fault outlets in kitchen and bathroom?
- Light switch at the entrance to each room
- Outlet height, wall locations
- Low vision/sound warnings available?
- Extension cord hazard?
- Are there any uncovered outlets or switches?

Please document below any deficiencies and recommendations for safety improvement

12. HEAT, LIGHT, VENTILATION, SMOKE, CARBON MONOXIDE, WATER TEMP CONTROL

- Are there smoke/CO alarms and a fire extinguisher?
- Are Thermostat displays easily accessible and readable?
- Note rooms where poor light level exists
- Able to open windows; slide patio doors?
- Able to open drapes or curtains?
- Note last service date for heating/cooling system
- Observe temperature setting of the water heater

Please document below any deficiencies and recommendations for safety improvement

Washtenaw/Livingston Medical Control Authority
Community Paramedicine Protocols
IMMUNIZATIONS

Date: October 2014

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Immunizations

Indications: This protocol provides general guidance for providing immunizations to patients under the Community Paramedicine Program. The CPU will respond to a residence on request from the primary care provider, on request by the patient/parent of patient through 911 triage or on referral from ALS 911 response. The CP will follow guidelines outlined by the primary care providers or on-line medical direction orders for the provision of immunizations for patients.

Purpose: The CP may provide vaccinations for seasonal influenza, pneumonia or other immunization as directed by the PCP or other patient provider. Community immunization and other public health applications are important duties CPs may perform as determined necessary in cooperation with the PCP, medical control authority and the local public health department. Training will be approved by the CPMP Medical Director and may be accomplished under the direction of the PCP or CPMP Medical Director and/or local public health department. Communicate with the primary care provider or on-line medical direction on the condition of the patient as well as on the general well-being of the patient as well as continuing medication reconciliation and continuity plan.

CPU Directives:

1. Follow **General Protocol for CPU Patient Assessments** as indicated.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. Indications for immunization:
 - a. CPU patients may be immunized or tested for TB under guidelines developed by the public health department or MCA.
 - b. Timing of immunizations will be determined by the PCP and public health department to comply with public health needs.
 - c. Immunizations may be performed in the residence, clinic, NEHC, mass immunization or setting as approved by the CPMP Medical Director, MCA and/or local public health department.
4. Immunization
 - a. Immunizations may be administered via IM, SQ or intranasal route in dosing determined by guidance provided by the PCP or local public health department as required for the agent administered.
 - b. Pre immunization screening will be performed as determined appropriate for the agent administered by the PCP, MCA or local health department.
5. Training
 - a. Training for immunization will be provided by local public health department personnel or under an approved MCA program.

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IMMUNIZATIONS

Date: October 2014

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6. Record keeping
 - a. A record of patients receiving immunizations will be maintained by the agency performing the immunizations as determined by the local public health department/Medical Control Authority.
 - b. Michigan Care Improvement Registry (MCIR) record keeping may be required for some immunizations.

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Community Paramedicine Protocols
I-STAT

Date: October 2014

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I-STAT

Indications: This protocol provides guidance for obtaining I-STAT values on the request of the PCP under the Community Paramedicine Program.

The CPU will respond to a residence for I-STAT value determination on a request from the primary care provider, on request by the patient through 911 triage or on referral from ALS 911 response.

Purpose: To assist the medical provider in obtaining certain blood laboratory values while in the patients home. Communicate with the primary care provider or on-line medical direction on the condition of the patient as well as on the I-STAT values determined and continuity plan.

CPU Directives:

1. Follow **General Protocol for CPU Patient Assessments** as indicated.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. Using universal precautions, obtain sample of patient's venous blood with use of a butterfly needle of at least 20 g and a green top blood tube.
4. Roll the tube back and forth in hands at least 5 (five) times.
5. Using a 1 cc syringe with at least a 20-gauge needle, withdraw 1 cc blood from the green top tube.
6. Expel 2 drops of blood from the syringe prior to filling I-STAT chamber.
7. Remove cartridge from the package handling the cartridge from the sides only.
8. Place cartridge on a flat surface.
9. Fill the cartridge with the blood sample only to the appropriate level as marked on the cartridge.
10. Close cover over sample well.
11. Turn on I-STAT and enter operator and patient ID numbers.
12. Insert cartridge into analyzer (Do not remove while "cartridge locked" message is on).
13. Record the results on the EPCR and communicate the results to the PCP or on-line medical direction.

Precautions

1. Avoid drawing blood from an arm with an IV already in place as this will dilute the sample and may interfere with test results.
2. Venous stasis as with prolonged tourniquet application may alter lab results.
3. Avoid having the patient use extra muscle activity such as clenching the fist as this may increase potassium results.

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Community Paramedicine Protocols
I-STAT

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Special Notes

1. Cartridges are good for two (2) weeks at room temperature.
2. Lab results will not be interpreted in the field alone and will always be sent to the referring PCP or on-line medical direction.
3. If the CP notices a possible life threatening abnormal lab value, they will immediately contact the referring PCP or on-line medical direction to discuss the results and determine treatment and disposition.

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Community Paramedicine Protocols
LAB DRAW

Date: October 2014

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Lab Draw

Indications: This protocol provides guidance for obtaining a lab specimen for testing on the request of the PCP under the Community Paramedicine Program.

The CPU will respond to a residence for I-STAT value determination on a request from the primary care provider, on request by the patient through 911 triage or on referral from ALS 911 response.

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

CPU Directives:

1. Follow **General Protocol for CPU Patient Assessments** as indicated.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. Perform the lab draw using universal precautions.
4. Blood tubes should be collected in the order of red, green, purple, pink, and blue.
5. Fill out the label for each of the tubes to include the patient's name, date of birth, CP's initials, and date and time of the lab draw. Pre-completed label may also be used when available.
6. Affix the label to the blood tubes.
7. Complete the lab paperwork provided by the PCP's office or hospital lab.
8. Place the samples in a biohazard bag.
9. Deliver samples to the appropriate ordering PCP's office or hospital lab.

Washtenaw/Livingston Medical Control Authority
Community Paramedicine Protocols
IV CATHETER CHANGES

Date: October 2014

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IV Catheter Changes

Indications: This protocol provides guidance for the removal and reinsertion of intravenous (IV) catheters under the Community Paramedicine Program. The CPU will respond to a residence for removal and reinsertion of IV catheters on request from the primary care provider, on request by the patient through 911 triage or on referral from ALS 911 response.

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

CPU Directives:

1. Follow **General Protocol for CPU Patient Assessments** as indicated.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. Be aware of complications of long-term catheter use and effects of termination of IV. Educate patient on signs of infection.
4. Take into account certain medications, which could lead to uncontrolled bleeding.
5. Using universal precautions remove and reinsert the IV catheter. Assure patency with flush and blood return.
6. Communicate any unusual findings with PCP or on-line medical direction.

Washtenaw/Livingston Medical Control Authority
Community Paramedicine Protocols
GI COMPLAINTS

Date: October 2015

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GI Complaints

Indications: This protocol provides guidance for the evaluation and treatment of a patient with GI complaints under the Community Paramedicine Program. The CPU will respond to a residence evaluation and treatment of a patient with GI complaints on request from the primary care provider, on request by the patient through 911 triage or on referral from ALS 911 response.

Purpose: Evaluation and treatment of patients with presumed simple GI complaints. These would include nausea, vomiting and/or diarrhea of short duration without signs of hemodynamic compromise or significant abdominal pain.

CPU Directives:

1. Follow **General Protocol for CPU Patient Assessments** as indicated.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. Using universal precautions start an IV and administer NS IV/IO fluid bolus up to 1 liter, wide open.
4. Administer additional IV fluid boluses, as indicated by hemodynamic state. Continue IV fluid bolus to a maximum of 2 liters.
5. Contact the patient's PCP or on-line medical direction, provide a patient report and determine whether on-scene treatment is appropriate.
6. For a patient with nausea and/or vomiting administer Ondansetron (Zofran) 4mg PO(ODT)/IV/IM. If nausea and/or vomiting persist after 45 minutes repeat Ondansetron (Zofran) 4mg PO(ODT)/IV/IM.
7. After treatment the patient should be reassessed. Treatment goals include: the cessation of nausea and/or vomiting, toleration of PO fluids, cessation of and abdominal symptoms and indications of complete rehydration such as lack of orthostatic vital sign changes.
8. Contact the patient's PCP or on-line medical direction, provide a revised patient report and determine appropriate disposition and continuity plan. This plan may include a prescription for anti-emetics, scheduled reevaluation as determined by the PCP or on-line medical direction.

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Community Paramedicine Protocols
FOLEY CATHETER CARE

Date: February 2015

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Foley Catheter Care

Indications: This protocol provides general guidance for the evaluation of patients with Foley Catheter problems under the Community Paramedicine Program. These complaints may include blocked Foley, damaged or the need for replacement of the catheter. The CPU will respond to a residence on request from the primary care provider, on request by the patient through 911 triage or on referral from ALS 911 response. The CP will follow guidelines outlined by the primary care providers or on-line medical direction orders.

Purpose: To assess complaints related to Foley catheters.

CPU Directives:

1. Follow **General Protocol for CPU Patient Assessments**.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. Examine the Foley catheter for patency, functionality and placement.
4. If there is evidence of Foley catheter blockage, using sterile technique flush the Foley catheter using sterile Saline. If unable to establish good flow, consider Foley catheter replacement.
5. If the Foley Catheter is non-functional, damaged or has become displaced, consider Foley Catheter replacement.
6. If the Foley Catheter is replaced, use sterile technique and obtain a urine sample for urine dip stick.
7. Report the dip stick results to on-line medical direction. As the Foley Catheter may be colonized with bacteria making the dipstick unreliable, treat the patient as directed by on-line, refer to **Urinary Complaints** protocol.
8. Contact the PCP or on-line medical direction per the **General Protocol for CPU Patient Assessments**. Along with the patient report, give the results of the urine dipstick, if obtained, and discuss treatment and continuity plans.
9. Continue treatment and follow the **General Protocol for CPU Patient Assessments** until a disposition is determined and continuity plan completed.

Washtenaw/Livingston Medical Control Authority
Community Paramedicine Protocols
FEEDING TUBE CARE

Date: March 2015

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Feeding Tube Care

Indications: This protocol provides general guidance for the evaluation of patients with Feeding Tube problems under the Community Paramedicine Program. These complaints may include feeding tube blockage, damage or the need for replacement of the Feeding Tube. The CPU will respond to a residence on request from the primary care provider, on request by the patient through 911 triage or on referral from ALS 911 response. The CP will follow guidelines outlined by the primary care providers or on-line medical direction orders.

Purpose: To assess complaints related to Feeding Tubes.

CPU Directives:

1. Follow **General Protocol for CPU Patient Assessments**.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. Examine the feeding tube for patency, functionality and placement.
4. Attempt to identify the type of feeding tube.
5. If there is evidence of feeding tube blockage, flush the tube using a small (approx. 10 ml) syringe. If unable to establish good flow and the tube is in place, consider making arrangement for feeding tube replacement.
6. If the feeding tube is non-functional, damaged or has become displaced, consider replacement of the tube, if indicated, or making arrangement for feeding tube replacement.
7. If the feeding tube has become displaced, consider placement of a temporary Foley Catheter in the existing tract if indicated.
8. Contact the PCP or on-line medical direction per the **General Protocol for CPU Patient Assessments** along with the patient report and discuss treatment and continuity plans.
9. Continue treatment and follow the **General Protocol for CPU Patient Assessments** until a disposition is determined and continuity plan completed.

Washtenaw/Livingston Medical Control Authority
Community Paramedicine Protocols
DIABETIC PATIENTS

Date: March 2015

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Diabetic Patients

Indications: This protocol provides general guidance for the evaluation of patients with hyperglycemia or hypoglycemia related to known diabetes under the Community Paramedicine Program. The CPU will respond to a residence on request from the primary care provider, on request by the patient through 911 triage or on referral from ALS 911 response. Hypoglycemic patients who cannot be cleared by ALS 911 response will likely need transport to the ED. The CP will follow guidelines outlined by the primary care providers or on-line medical direction orders.

Purpose: To assess the diabetic patient and treat patients with extremes of blood glucose who do not require urgent ED evaluation. Patients who should be transported immediately include those who have significant vital sign abnormalities or signs of significant infection.

CPU Directives:

1. Follow **General Protocol for CPU Patient Assessments**.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available. If not already done, measure the blood glucose level.

Hypoglycemia

3. Hypoglycemic patients who cannot be cleared by ALS 911 response will likely need transport to the ED. If the CP is in attendance for the hypoglycemic patient treat as follows.
4. If the patient is alert but demonstrating signs of hypoglycemia and the blood glucose is less than 60 mg/dl administer oral high caloric fluid.
5. If patient is not alert or vital signs are unstable:
 - a. Evaluate and maintain airway, provide oxygenation and support ventilations as needed. Consider immediate transport.
 - b. If no suspected spinal injury, place the patient on either side.
6. If glucose is less than 60 mg/dl, and patient is demonstrating signs of hypoglycemia:
 - a. Administer Dextrose 50%, 25 grams (50 ml) IV or small amounts of oral glucose paste, buccal or sublingual.
7. Once the patient becomes alert, feed the patient and assess for infection or other complicating issues.
8. Recheck the blood glucose 10 minutes after glucose administration. Recheck as indicated.

Hyperglycemia

9. Assess the patient's medication compliance and diet.
10. Obtain a blood sample for I-STAT evaluation, see **I-STAT** protocol.
11. Assist the patient in the administration of their own diabetic treatment medications as indicated.

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Community Paramedicine Protocols
DIABETIC PATIENTS

Date: March 2015

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12. Consider administration of IV fluid boluses as indicated.
13. Recheck blood glucose and reassess the patient every 30 minutes during treatment.
14. Contact the PCP or on-line medical direction per the **General Protocol for CPU Patient Assessments** along with the patient report and discuss treatment and continuity plans.
15. Continue treatment and follow the **General Protocol for CPU Patient Assessments** until a disposition is determined and continuity plan completed.

Washtenaw/Livingston Medical Control Authority
Community Paramedicine Protocols
UPPER RESPIRATORY INFECTION

Date: February 2015

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Upper Respiratory Infection

Indications: This protocol provides general guidance for the evaluation of patients with presumed upper respiratory infection complaints under the Community Paramedicine Program. The CPU will respond to a residence on request from the primary care provider, on request by the patient through 911 triage or on referral from ALS 911 response. The CP will follow guidelines outlined by the primary care providers or on-line medical direction orders.

Purpose: To assess the patient with upper respiratory complaints and differentiate patient who can be treated supportively vs those who will require ED evaluation.

CPU Directives:

1. Follow **General Protocol for CPU Patient Assessments**.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. Patients with significant abnormalities in vital signs or hypoxia on room air or their prescribed home oxygen should be transported for ED evaluations.
4. If the patient has wheezing treat per the **Asthma/COPD** protocol.
5. Provided there is no fever, hypoxia or significant wheezing not cleared with treatment, the patient may be a candidate for home supportive treatment.
6. Contact the PCP or on-line medical direction per the **General Protocol for CPU Patient Assessments** along with the patient report and discuss treatment and continuity plans.
7. Continue treatment and follow the **General Protocol for CPU Patient Assessments** until a disposition is determined and continuity plan completed.

Washtenaw/Livingston Medical Control Authority
Community Paramedicine Protocols
CONTINUITY PLANNING

Date: October 2015

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Continuity Planning

Indications: This protocol provides general guidance for continuity planning for patients treated under the Community Paramedicine Program. The CPU will respond to a residence on request from the primary care provider, on request by the patient through 911 triage or on referral from ALS 911 response. The CP will follow guidelines outlined by the primary care providers or on-line medical direction orders.

Purpose: To establish a continuity plan for patients evaluated and treated under the Community Paramedicine Program.

CPU Directives:

1. Follow **General Protocol for CPU Patient Assessments**.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. Patients treated under the Community Paramedicine Program will be provided a written Continuity Plan which will include:
 - a. Follow up evaluation: In cooperation with the patient and online medical direction the CP will provide a **Follow Up Location** will be defined with a plan for successful completion of the follow up. The follow up may include, but is not limited to, immediate office evaluation, delayed office evaluation, return visit(s) by the Community Paramedic, other home care treatment plan, other defined follow up location.
 - b. Medication reconciliation: In cooperation with the patient and on-line medical direction the CP will provide a **Medication Reconciliation** for the patient. The plan should include an assessment of the prescribed medications and the ability of the patient to understand the medication they are to be taking. If additional medications are needed, the CP will help to develop a plan for assuring the patient has what is needed. The CP may call in medication to a pharmacy of the patient's choice at the direction of the on-line medical direction physician.
 - c. Additional treatment: In cooperation with the patient and on-line medical direction the CP will provide a plan for **Additional Treatment** when needed. This plan may include arrangements for additional home visits by medical professionals, delivery on home medical equipment or other treatments needed for the patient.
4. Contact the PCP or on-line medical direction per the **General Protocol for CPU Patient Assessments**. Along with the patient report discuss treatment and continuity plans.
5. Continue treatment and follow the **General Protocol for CPU Patient Assessments** until a disposition is determined and continuity plan completed.

Washtenaw/Livingston Medical Control Authority
Community Paramedicine Protocols
ELEVATED BLOOD PRESSURE

Date: March 2015

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Elevated Blood Pressure

Indications: This protocol provides general guidance for the evaluation of patients with the complaint of elevated blood pressure under the Community Paramedicine Program. The CPU will respond to a residence on request from the primary care provider, on request by the patient through 911 triage or on referral from ALS 911 response. The CP will follow guidelines outlined by the primary care providers or on-line medical direction orders.

Purpose: To assess the patient with elevated blood pressure and differentiate between the patient who can be treated supportively vs. those who will require ED evaluation.

CPU Directives:

1. Follow **General Protocol for CPU Patient Assessments**.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. Obtain manual and automated vital sign readings and obtain patient hypertensive medication prescription and usage.
4. Determine whether the patient has additional symptoms which may be related to the elevated blood pressure such as: chest pain, shortness of breath, other pain, headache or neurologic symptoms. Symptomatic patients should be considered for transport to the ED for evaluation.
5. Asymptomatic hypertensive patients are appropriate for home treatment and close follow up. Blood pressures with systolic below 220 and diastolic below 120 may be appropriate for home treatment.
6. Contact the PCP or on-line medical direction per the **General Protocol for CPU Patient Assessments**. Provide patient report and discuss treatment and continuity plans.
7. Continue treatment and follow the **General Protocol for CPU Patient Assessments** until a disposition is determined and continuity plan completed.

Washtenaw/Livingston Medical Control Authority
Community Paramedicine Protocols
SUTURE REMOVAL

Date: March 2015

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Suture Removal

Indications: This protocol provides general guidance for the evaluation of patients with the need of suture removal under the Community Paramedicine Program. The CPU will respond to a residence on request from the primary care provider, on request by the patient through 911 triage or on referral from ALS 911 response. The CP will follow guidelines outlined by the primary care providers or on-line medical direction orders.

Purpose: To assess the patient with wounds that have been closed with suture or staples and differentiate between the patient who can be treated at home vs. those who will require ED evaluation.

CPU Directives:

1. Follow **General Protocol for CPU Patient Assessments**.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. Assess the patient's wound and determine the following:
 - a. Mechanism of injury
 - b. Date of injury and wound repair
 - c. Type of wound closure: staples, suture absorbable vs synthetic (e.g. nylon)
 - d. Care of wound since closure
 - e. Recommended time for closure devices to be removed
 - f. Appearance of wound: clean and dry, drainage seen, color of surrounding skin, swelling or pain experienced by the patient.
4. Determine whether the patient has additional symptoms which may be related to wound complications such as: fever, local redness or swelling, red streaks proximal to the wound. Symptomatic patients should be considered for transport to the ED for evaluation.
5. Asymptomatic patients are appropriate for home treatment, suture/staple removal and appropriate follow up.
6. Contact the PCP or on-line medical direction per the **General Protocol for CPU Patient Assessments**. Provide patient report and discuss treatment and continuity plan.
7. Continue treatment and follow the **General Protocol for CPU Patient Assessments** until a disposition is determined and continuity plan completed.

Washtenaw/Livingston Medical Control Authority
Community Paramedicine Protocols
SKIN INFECTION (CELLULITIS)

Date: March 2015

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Skin Infection (Cellulitis)

Indications: This protocol provides general guidance for the evaluation of patients with possible cellulitis under the Community Paramedicine Program. The CPU will respond to a residence on request from the primary care provider, on request by the patient through 911 triage or on referral from ALS 911 response. The CP will follow guidelines outlined by the primary care providers or on-line medical direction orders.

Purpose: To assess the patient with possible cellulitis and differentiate between the patient who can be treated at home vs. those who will require ED evaluation.

CPU Directives:

1. Follow **General Protocol for CPU Patient Assessments**.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. Assess the patient's area of concern and determine the following:
 - a. Presence or absence of injury
 - b. Location and extent of skin changes
 - c. Additional local symptoms: redness, drainage, weeping, ascending redness, warmth of the skin
 - d. Presence of systemic symptoms: fever, chills, diaphoresis, weakness, dizziness, changes in mental status
4. Patients with systemic symptoms should be transported to the ED for evaluation.
5. Patients without systemic symptoms may be appropriate for home treatment, and close follow up.
6. Contact the PCP or on-line medical direction per the **General Protocol for CPU Patient Assessments**. Provide patient report and discuss treatment and continuity plan.
7. Continue treatment and follow the **General Protocol for CPU Patient Assessments** until a disposition is determined and continuity plan completed.

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Community Paramedicine Protocols
SKIN RASH

Date: March 2015

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Skin Rash

Indications: This protocol provides general guidance for the evaluation of patients with possible skin rash under the Community Paramedicine Program. The CPU will respond to a residence on request from the primary care provider, on request by the patient through 911 triage or on referral from ALS 911 response. The CP will follow guidelines outlined by the primary care providers or on-line medical direction orders.

Purpose: To assess the patient with possible skin rash and differentiate between the patient who can be treated at home vs. those who will require ED evaluation.

CPU Directives:

1. Follow **General Protocol for CPU Patient Assessments**.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. Assess the patient's area of concern and determine the following:
 - a. History of exposure to possible allergen (oral) or skin contact exposure (poison ivy/oak)
 - b. Location and extent of skin changes
 - c. Additional local symptoms: redness, drainage, weeping, ascending redness, warmth of the skin
 - d. Presence of systemic symptoms: fever, chills, diaphoresis, weakness, dizziness, changes in mental status or breathing difficulty
4. Patients with systemic symptoms should be transported to the ED for evaluation.
5. Patients with acute symptoms should be treated per appropriate EMS protocol.
6. Patients without systemic symptoms may be appropriate for home treatment, and close follow up.
7. Contact the PCP or on-line medical direction per the **General Protocol for CPU Patient Assessments**. Provide patient report and discuss treatment and continuity plan.
8. Continue treatment and follow the **General Protocol for CPU Patient Assessments** until a disposition is determined and continuity plan completed.

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Community Paramedicine Protocols
SICK PERSON

Date: March 2015

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Sick Person

Indications: This protocol provides general guidance for the evaluation of patients with non-specific sick person complaints under the Community Paramedicine Program. The CPU will respond to a residence on request from the primary care provider, on request by the patient through 911 triage or on referral from ALS 911 response. The CP will follow guidelines outlined by the primary care providers or on-line medical direction orders.

Purpose: To assess the patient with nonspecific sick person complaints and differentiate between the patient who can be treated at home vs. those who will require ED evaluation.

CPU Directives:

1. Follow **General Protocol for CPU Patient Assessments**.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. Assess the patient's complaints and determine the following:
 - a. History of current complaints
 - b. Presence of systemic symptoms: fever, chills, diaphoresis, weakness, dizziness, changes in mental status, breathing difficulty, chest pain, other systemic symptoms, alterations in vital signs
4. Patients with systemic symptoms or vital sign changes may need transported to the ED for evaluation.
5. Patients without systemic symptoms may be appropriate for home treatment, and close follow up.
6. Contact the PCP or on-line medical direction per the **General Protocol for CPU Patient Assessments**. Provide patient report and discuss treatment and continuity plan.
7. Continue treatment and follow the **General Protocol for CPU Patient Assessments** until a disposition is determined and continuity plan completed.

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Community Paramedicine Protocols
NOSE BLEED

Date: October 2015

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Nose Bleed

Indications: This protocol provides general guidance for the evaluation of patients with complaint of nose bleed under the Community Paramedicine Program. The CPU will respond to a residence on request from the primary care provider, on request by the patient through 911 triage or on referral from ALS 911 response. The CP will follow guidelines outlined by the primary care providers or on-line medical direction orders.

Purpose: To assess the patient with a nose bleed, provide initial treatment and differentiate between the patient whom can be treated at home vs those who will require ED evaluation.

CPU Directives:

1. Follow **General Protocol for CPU Patient Assessments**.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. If the patient has active bleeding on in initial evaluation provide direct pressure to the nose as soon as possible while obtaining additional history.
4. Evaluate the patient's history and determine the following:
 - a. Time of onset of current nose bleed
 - b. History of previous bleeds and treatment required
 - c. Use of medication which may affect treatment of the nose bleed: Aspirin, systemic anticoagulants (Lovenox, Coumadin, other anticoagulants)
 - d. Assess vital signs
 - d. Presence of systemic symptoms: fever, chills, diaphoresis, weakness, dizziness, changes in mental status, breathing difficulty, chest pain, other systemic symptoms
5. Assess Hgb and INR, if available, for patients with significant bleeds or patients taking Coumadin
6. Patients with systemic symptoms or vital sign changes or significant lab abnormalities may need transported to the ED for evaluation.
7. Patients without systemic symptoms and stable vital signs may be appropriate for home treatment, and close follow up.
8. Provide direct pressure for an initial period of 10-15 minutes. Reassess after this period. If the initial treatment is not successful, repeat the direct pressure treatment. Try to keep the patient from swallowing blood which may be irritating to the GI tract and result in vomiting of blood.
9. In addition to direct pressure or if the initial direct pressure application during history collection is unsuccessful, consider oxymetazoline 2-3 sprays in the affected nostril(s).
10. If direct pressure is successful in controlling the bleeding, give the patient and family education as to the typical treatment of nose bleeds, self-treatment options prevention options.

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Community Paramedicine Protocols
NOSE BLEED

Date: October 2015

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11. Contact the PCP or on-line medical direction per the **General Protocol for CPU Patient Assessments**. Provide patient report and discuss treatment and continuity plan.
12. Continue treatment and follow the **General Protocol for CPU Patient Assessments** until a disposition is determined and continuity plan completed.

Alternative Destination & Alternative Transport

Indications: This protocol provides general guidance for the patient who may be transported to a destination other than a hospital emergency department when appropriate under the Community Paramedicine Program. It also provides guidance when transportation other than an ambulance may be appropriate under the Community Paramedicine Program. The CPU will respond to a residence on request from the primary care provider, on request by the patient through 911 triage or on referral from ALS 911 response. The CP will follow guidelines outlined by the primary care providers or on-line medical direction orders.

Purpose: To assess the patient who might be appropriate for alternative transport or alternative destination.

ALTERNATIVE DESTINATION

CPU Directives:

1. Follow **General Protocol for CPU Patient Assessments**.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. Follow appropriate CPU protocols for the patient's complaint.
4. Contact the PCP or on-line medical direction per the **General Protocol for CPU Patient Assessments**. Provide patient report and discuss treatment and continuity plan.
5. Continue treatment and follow the **General Protocol for CPU Patient Assessments** until a disposition is determined and continuity plan completed.
6. Emergency patients requiring treatment will be transported by an EMS agency to a hospital emergency facility, freestanding surgical outpatient facility or hospital-based emergency department that operates a service for treating emergency patients 24 hours a day, seven days a week.
7. A patient may be transported to an alternative non-emergency facility (alternative destination), such as a doctor's office or clinic provided the patient, family or on-line medical direction requests/suggests the alternative destination and the patient is clearly stable and it has been determined that an emergency no longer exists.

ALTERNATIVE TRANSPORT

CPU Directives:

1. For a patient for whom it has been determined that an emergency does not exist and for whom an evaluation or scheduled visit at a doctor's office, clinic or other alternative destination is desired as part of the continuity plan, an alternative form of transport may be considered. This might include a private car, taxi, wheel chair van or other non-emergency medical transport vehicle.