Lebanon Fire Department and Dartmouth Hitchcock Medical Center Mobile Integrated Health (MIH) Program Operational Toolkit

Mobile Integrated Health
Healthcare in the comfort of your home
Dartmouth Health

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https://re-aim.org/

https://www.hipxchange.org/C-TraC

Background

Overview

Nationally and locally, health systems and community organizations are working together to meet the health needs of our populations and address escalating health care costs. Increasingly, community emergency services are evolving as partners in the larger health ecosystem; an ecosystem which links traditional health care providers and community-based organizations in a coordinated system of care. Mobile Integrated Health programs are one type of program that can support patients in their communities. One component of Mobile Integrated Health, Community Paramedicine, is defined by the National Rural Health Association as “an organized system of services, based on local need, which are provided by EMTs and paramedics integrated into the local or regional health care systems and overseen by emergency and primary care physicians”.

Paramedicine Programs operate in communities to prevent unnecessary emergency transports and hospital admissions as well as to follow up with patients after discharge to prevent hospital readmissions, among other functions.

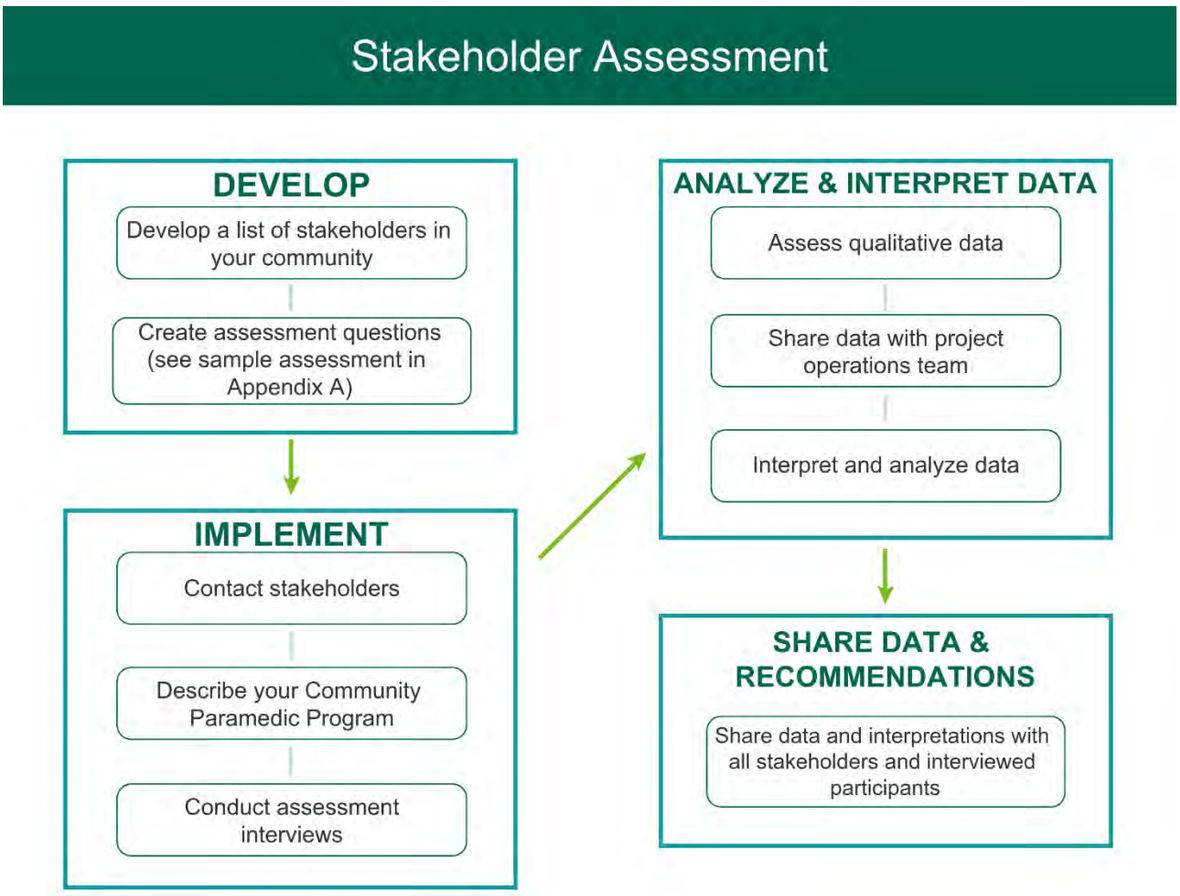
The goal of this toolkit is to help health systems and community organizations work together to meet the health needs of their communities through leveraging the skills of emergency medical services by standing up Community Paramedicine programs. This will be achieved through sharing the practices, procedures, and lessons learned by the Dartmouth-Hitchcock and Lebanon Fire Department Mobile Integrated Health Program.

Who should use this toolkit and why?

This toolkit is intended for Hospital systems and local Emergency Medical Service providers to use collaboratively in the planning and development phase of program implementation. The intention of this toolkit is to help guide the process of integrating community paramedicine into the workflows and procedures of the local hospital system partner. Additionally, this toolkit will offer strategies to educate providers on the benefits of community paramedicine and how they can leverage this resource for their patients in an effective way.

Phase 1: Determining Local Need

Stakeholder Assessment



Goals and Objectives

Year 1 Program Objectives

- State licensing and certification (program approval)
- Establish infrastructure to run the program
  - Governance System
  - Education and Training
  - Data systems and collection
  - Referral processes
    - Transitional care management; partnership with the Levi
  - Documentation and record keeping (eD-H)
  - Communication plan
  - Obtain required equipment
- Hire the paramedic
- Meet with and identify referral sources to roll out the program
- Identify advisory council from the community and hold initial meetings
- Integration of community nurses into Leb Fire/MIH program
- Enroll initial cohort of patients

Year 2 Program Objectives

- Increase volume of patients served over the first year
- Increase the number of appropriate referral sources over the first year
- Evaluate and respond to feedback collected in patient/provider feedback
  - "Commit to continuous improvement through evaluation of patient and provider feedback"
- Consolidating lessons learned and create a toolkit to capture learning and disseminate to others
- Hold three advisory council meetings

Phase 2: Planning and Development

Application:

Vermont Mobile Integrated Healthcare/Community Paramedicine Program report found here

Maine Community Paramedicine Resources can be found here

Massachusetts Mobile Integrated Health Care and Community EMS resources can be found here

Applications to operate a Mobile Integrated Health/Paramedicine program will vary from state to state, but are likely to include the same key elements and requirements. The New Hampshire application outlines these requirements, offering a description for what each section should include.

Click the link below to access the NH state application. Additionally, outlined below is each section required in the NH application and tips for what to include for a strong application and ultimately, a successful program.

New Hampshire:

https://www.nh.gov/safety/divisions/fstems/ems/documents/mihadministration.pdf

Information needed as part of the NH state application:

Section 1: Letter of Intent
Section 2: Scope of Project
Section 3: General Project Description including Needs Assessment Tool
Section 4: Patient Interaction Plan
Section 5: Staffing Plan
Section 6: Training Plan
Section 7: Medical Direction/ Quality Management Plan
Section 8: Data Collection and Plan

Phase 3: Program Model

Target Patient; Who Community Paramedic is Designed to Help

- Age 18 years or older
- Resides in City of Lebanon (includes West Lebanon)
- Has established relationship with a Dartmouth Health provider (Primary or Specialty Clinic)
- Able to participate in their own care (excludes dementia, severe persistent mental health), **or** patient has a Caregiver who can be present during visits
- Will benefit from short-term medical intervention(s) aimed at an acute condition or exacerbation of a chronic condition
- Not receiving similar services from another organization (vising nurse and hospice)

Processes and Procedures

Referrals- see reasons for referrals below.

Patient Enrollment-

Upon Receipt of a Referral

- Confirm that Referral meets program criteria:
  - COVID NEGATIVE ONLY
  - Age 18 years or older
  - Resides in City of Lebanon (includes West Lebanon)
  - Has established relationship with a DHH provider (Primary or Specialty Clinic)
  - Able to participate in their own care (excludes dementia, severe persistent mental health), or patient has a Caregiver who can be present during the visit

    - Will benefit from short-term intervention(s) aimed at an acute condition or exacerbation of a chronic condition
    - Not receiving similar services from another organization (ie VNH wound care)
- Confirm that a referring provider is listed
- Confirm the order
- If any information is missing or unclear follow up with the person sending the referral.
- Perform a brief chart review:
    - PPMHx
    - Problem List
    - Number of Medications
- Call the Patient:
    - Confirm the correct patient (Name, DOB)
    - Explain the program
    - Explain what to expect from the first visit
    - Schedule Visit.
- Complete MIH Intake Note in Epic
- Complete TEMSIS- MIHC encounter reporting

Initial Home Visit

- Arrive at the home
    - Introductions
    - Confirm the correct patient (Name, DOB)
    - Explain what to expect at the visit
    - Obtain Consent Signature in TEMSIS Field Bridge
- Identify Patients Medical Concerns
- Identify Patients Goals.
- Medication Reconciliation:
    - Total number of medications reviewed
    - Number of meds taking correctly
    - Number of incorrect medications: prescribed but not taking
    - Number of incorrect medications: taking but not prescribed
    - Correct medications taking incorrectly
    - System for ensuring medications are taken correctly
    - Challenges for taking medications correctly.
- Determine Social History: This is most commonly done as casual conversation throughout the visit:
    - Medication availability
    - Access to healthcare
    - Health Insurance
    - Finances
    - Housing
    - Food
    - Utilities (phone, heat, water)
    - Transportation
    - Work/Job training
    - Personal safety
    - Children/Childcare
    - Other
- Home Safety Assessment:
    - Heating / Cooling
    - Plumbing
    - Electricity
    - Trip / Fall hazards
    - Food safety
    - Mobility / Access
    - Mold
    - Pests
    - Fire Safety
        - Fire load
        - Smoke detectors
- Physical Exam
    - Vital Signs
- Interventions as ordered
    - Treatments

    - Patient Education
- Conclusion
    - Review patients upcoming medical appointments
    - Schedule follow up if needed
    - If no, follow up needed:
        - complete patient satisfaction survey
        - Send provider and referring staff the provider satisfaction survey
- Complete Community Paramedic Home Visit Initial Note
- Complete TEMSIS- MIHC encounter reporting
- Care team outreach as needed

Follow UP Visits

- Arrive at the home
    - Introductions
    - Confirm the correct patient (Name, DOB)
    - Explain what to expect at the visit
- Discuss and react to any changes since the previous visit
    - General Health and wellbeing
    - Effectiveness of any interventions
    - Any other contacts with the health care system
    - Healthcare Goals
        - Progress
        - Decline
- Physical Exam
    - Vital Signs
- Interventions as ordered
    - Treatments
    - Patient Education
- Conclusion
    - Review patients upcoming medical appointments
    - Schedule follow up if needed
    - If no, follow up needed:
        - complete patient satisfaction survey
        - Send provider and referring staff the provider satisfaction survey
- Complete Community Paramedic Home Visit Initial Note
- Complete TEMSIS-MIHC encounter reporting
- Care team outreach as needed

Patient Encounters – smart phrase examples in **Appendix B**

Primary Components of MIH Community Paramedicine

Referrals

Potential Reasons for Referral from ED

- DM / Hyperglycemia / Hypoglycemia
- Asthma
- COPD
- CHF
- Allergic reaction / anaphylaxis
- Dehydration / Nausea-Vomiting / Mild AKI
- Cellulitis / Abscess
- Pneumonia
- Wound Care
- Ortho / splinting / casting follow-up
- Electrolyte abnormality
- Alcohol Withdrawal
- Home safety check
- Medication reconciliation
- Blood draw / lab acquisition

Potential Reasons for Referral from Specialty Care:

The Congestive Heart Failure Clinic at DHMC works with the MIH program to identify patients that may benefit from a home visit by a community paramedic. These visits can be helpful to assist with weight checks on patients, assess fluid status, identify patients that may benefit from diuresis, help patients follow patient specific action plans regarding diuresis, perform IV diuresis, and perform medication reconciliation and general education regarding congestive heart failure.

The Chronic Obstructive Pulmonary Disease Clinic DHMC also refers patient to the MIH program. These referrals are often for medication reconciliation and education about how to properly administer inhaled and nebulized medications, assessment of home for environmental triggers of patients' COPD, and repeat evaluation after therapy modifications.

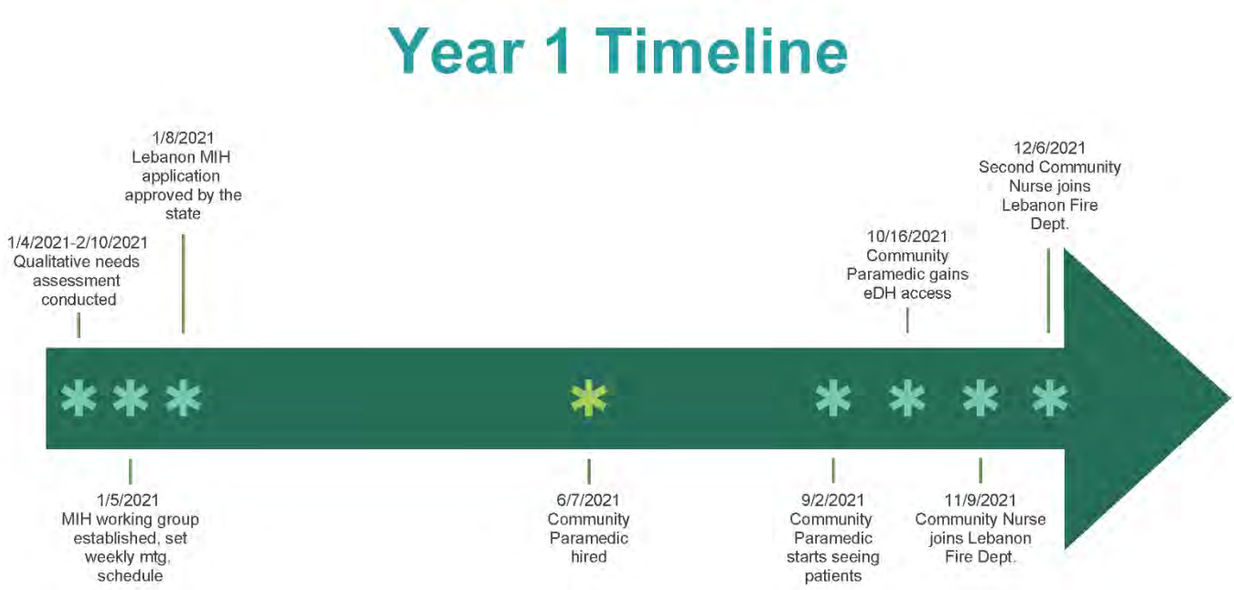
The Comprehensive Wound Healing Center at DHMC refers patients to the MIH program to assist with evaluation of wound healing progression, and performance of wound debridement and specialized dressing.

The Department of Anesthesia at DHMC has been working with the MIH program to refer geriatric patients undergoing surgery at DHMC or its Outpatient Surgical Center who would benefit from a home visit by a community paramedic, delivering the Care transitions intervention model. A 4 week program designed to allow patients to learn self-management skills that ensure their needs are being met during the transition from hospital to home.

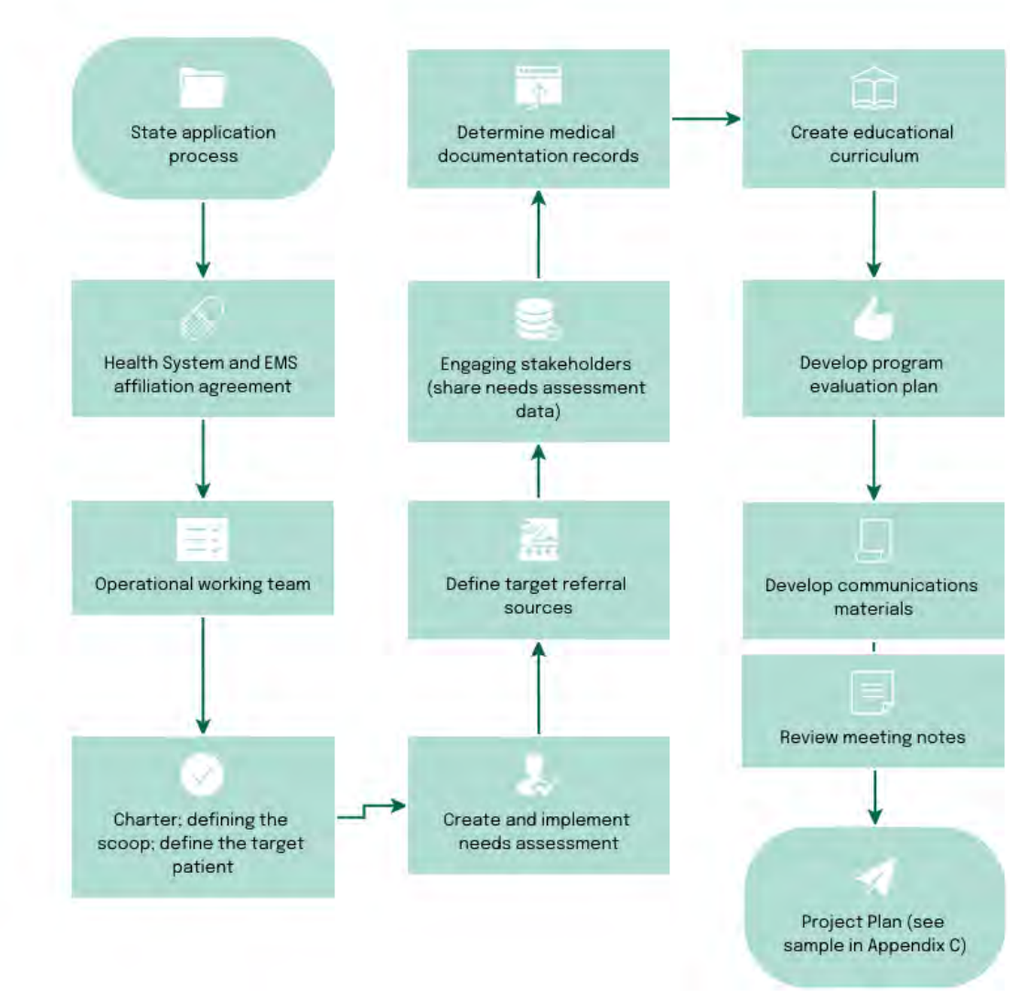
- Referrals from a Community Nurse counterpart; non-DH Provider:
    - Capture as a straight EMS run, with EMS number. From Medical Direction standpoint, this should not be an MIH visit. Implementation Best Practices

Reasons for referral to MIH from primary care:

- Care transitions (hospital to home)
- Chronic disease support
- Wound care
- VS monitoring / blood pressure check
- Medication reconciliation, compliance
- BP check
- Home safety evaluations



10 Key things prior to “turning the program on”



Phase 4: Program Implementation

Hiring: A multidisciplinary interview committee was created which included city and health system partners as well as the medical director. See sample job description in appendix D

Training and Education

The long term goal for this program is the development of a comprehensive educational curriculum that can be replicated and delivered to EMS providers not only at Lebanon Fire Department, but who are affiliated with other EMS agencies throughout the Upper Valley of New Hampshire and Vermont that are looking to establish MIH programs.

The educational curriculum has been delivered by appropriate subject matter experts including hospital based physicians, primary care / clinic based physicians, nurses, pharmacists, social workers, case managers, home health workers all affiliated with Dartmouth Hitchcock Health. The basis for this curriculum is the core content identified by the International Board of Specialty Certification for its Community Paramedic Certification. Community Health Paramedicine, (1st Edition) by the American Academy of Orthopedic Surgeons (AAOS), published by Jones & Bartlett Learning (2017) is the main text. The following Core Topics is covered by a combination of didactic, self-study, case based discussion, and clinical time:

1. COMMUNITY BASED NEEDS: a) Community health assessments b) Social determinants of health c) Potential community resources d) Existing community resources e) Cultural competence f) Special situations (e.g., bariatric care, high-risk pregnancy, mental health, substance/drug abuse, general special needs, abuse/neglect)
2. INTERDISCIPLINARY COLLABORATION: a) Chronic disease management b) Sub-acute disease management c) Acute disease management d) Professional

communication e) Community paramedic documentation f) How to access patient/client records g) How to review patient/client records h) Patient/Client record sharing i) Relevant past medical history

3. PATIENT / CLIENT CENTRIC CARE: a) How to acquire past medical history b) How to acquire disease specific (focused) history c) How to acquire medication history d) How to acquire psychosocial history e) Point of care testing f) Specimen collection, handling, transportation, and delivery g) Wound care therapies h) Wound care stages; Category i) Wound care devices j) Medication inventory k) Medication reconciliation l) Self-administered medication m) Teach back methodology n) Post-surgical care procedures o) Home medical equipment (e.g., nebulizers, CPAP, glucometers) p)How to approach end of life care q) Patient/Client needs assessment r) Urinary catheters (e.g., maintenance, post-diuresis weight) s) How to assess nutritional and hydration status t) Behavioral health screening u) Depression and suicide screen v) Palliative care w) Hospice care x) Lab values (e.g., coag studies, BMP, ABG, CBC, D-dimer, BNP) y) Implanted devices (e.g., VADs, PEG tubes, AICDs) z) chronic care conditions (e.g., CHF, COPD, diabetes, stroke, CAD, orthopedic, cancer, neurological disorders) aa) Sub-Acute medical conditions (e.g., post-surgical, post-discharge, poststroke care) bb) Acute medical conditions (e.g., asthma, stroke, exacerbations of chronic conditions, DVT, cold and flu, pneumonia) cc) Activities of daily living (ADLs) dd) Telehealth (e.g., phone calls, video calls, telemetry, remote patient monitoring, emails, texting)
4. COMMUNITY PARAMEDIC WELLNESS AND SAFETY: a) Levels of PPE (e.g., isolation precautions, barriers) b) Patient/client transfer techniques c) Stressors associated with paramedicine d) Situational awareness (e.g., patient/client family members, animals, egress, structural integrity, sanitation)
5. PREVENTATIVE CARE & EDUCATION FOR PATIENT/CLIENT & CAREGIVER: a) Education delivery processes b) Community paramedic education topics (e.g., risk safety, disease management, health care resources, medications, health care goals, nutrition, durable medical equipment, community resources) c) Safety risks for patient/client d) How to transition patient/client to independence
6. ETHICAL AND LEGAL CONSIDERATIONS: a) Professional boundaries (e.g., unscheduled visits, gift-giving and accepting, physical contact) b) Strategies to maintain professional boundaries c) Protected health information (PHI) security and maintenance strategies d) Best practices for community paramedics e) How to interpret legal documents (e.g., durable power of healthcare attorney, living will, guardianship) f) How to mitigate legal risk to individual, agency, and family (e.g., data security, sexual misconduct, theft) g) Patient/Client privacy h) Patient/Client rights i) Professional ethics

For the above noted core competencies, specific learning objectives have been developed for each. A gap analysis should then be performed for each individual learner to identify areas that require more or less instruction. A delivery plan should then formulated (utilizing a combination of case based discussions, self-study, didactics from subject matter experts, and clinical time in the emergency department, outpatient clinics, pharmacy, home health setting), and a formal assessment and credentialing process implemented.

In addition to one on one clinical time with the EMS and Primary Care Medical Directors to cover the above core topics, clinical rotations within specialty and primary care clinics can be valuable depending on the patient population the MIH providers will be responsible for seeing. Some examples of these clinics in which observation and hands on education can be beneficial are:

- Wound Care Clinic: Education delivered on assessment and staging of chronic wounds, various dressing and debridement techniques and supplies, and appropriate documentation

- Congestive Heart Failure (CHF) Clinic: Education delivered on physical exam findings and assessment of fluid overload, CHF specific medication management, patient education, and diuresis management

- Chronic Obstructive Pulmonary Disease (COPD) Clinic: Education delivered on physical exam findings of COPD patients at baseline and during flares, assessment and evaluation of home pulmonary function tests, patient education, and acute and chronic medication management of COPD

- Primary Care Triage Nurse: Education and observation with primary care clinic triage nurse, review of assessment algorithms, telephonic patient communication, and documentation

- Primary Care Clinical Pharmacist: Education delivered regarding medication reconciliation, common medication mistakes, and patient education

- Visiting Nurse Service: Education regarding VNA services, standard patient evaluations and home visit format, documentation, and interaction and communication with multidisciplinary teams

- Suture / Staple removal session: Education delivered regarding assessment of wounds for suture / staple removal, types of sutures / stitches / knots, equipment and tools for removal, and hands on practice of removal of sutures

Provider Outreach: Attended multiple clinical staff meetings to introduce the MIH program. See sample slide deck and broad communication to providers from Clinical Lead in appendix E

Patient Outreach: See sample patient brochure in appendix F

Phase 5: Program Evaluation

Evaluation Utilizing the Quadruple AIM

Improved Patient Experience:

1. **Patient Satisfaction with MIH program**
   - See sample evaluation in appendix G
2. **Patient self-assessment of health (how do you rate your overall health)**

Better Health Outcomes:

3. **ED visits for the 6m pre and 6m post referral/engagement**
   - Numerator 1: # ED visits of patients who engaged with MIH Program
   - Numerator 2: # ED visits of patients referred to MIH, but decline services or fail to connect
   - Denominator: Total # ED visits of patients referred to the program
4. **# ED Visits within 30 days of hospital discharge**
   - # of ED visits within 30 days of hospital discharge for patients referred to Community Paramedic while inpatient
5. **% of ED visits**
   - Numerator: # patients enrolled in the MIH program who visited the ED within past 6 months
   - Denominator: Total # MIH patients in the past 6 months

Lower Cost of Care:

6. **Ambulance dispatch 6m pre and 6 months post**
   - Numerator 1: # ambulance dispatch for patients who engaged with MIH program
   - Numerator 2: # ambulance dispatch for patients referred to MIH, but decline services or fail to connect
   - Denominator: Total # ambulance dispatch for patients referred to the program
   - Community Paramedic to collect this data via Image Trend
7. **Length of hospital stay for MIH enrolled patients**
   - # days in hospital

- Are patients who work with Community Paramedic able to go home sooner compared to those who did not?
- Are they admitted before health declines too much, compared to those who did not work with Community Paramedic

8. **Hospital readmissions within 30 days of hospital discharge**
   - Refer to date patient had visit with Community Paramedic while admitted; look at admissions 30 days after visit
   - Numerator: # hospital readmissions of patients engaged with MIH program
   - Denominator: Total # hospital readmissions of patients referred to the program
9. **% of hospital admissions**
   - Numerator: # patients enrolled in the MIH program admitted to the hospital within past 6 months
   - Denominator: Total # MIH patients in the past 6 months

Improved Staff Experience:

10. Dartmouth Hitchcock Medical Center provider satisfaction survey (insert in Appendix)
11. Lebanon Fire staff satisfaction survey (Appendix H)
12. Number of protocols and educational modules developed
    -

Quality of the program

Phase 6: Funding and Sustainability

Funding –

The Mobile Integrated Health program is funded through a Payment in Lieu of Taxes agreement with Dartmouth Hitchcock Medical Center and the City of Lebanon for an initial term of three years. If the program meets program objectives during the initial term then the initial term will be extended for an additional three years.

Strategies for Sustaining Community Paramedicine Programs*

Rural organizations can use different strategies for sustaining community paramedicine programs. When deciding which strategies to pursue, programs should consider their patient population, program activities, and funding mechanisms in their local health system and state Medicaid agencies. The Rural Community Health Toolkit provides information about general Sustainability Strategies and Sustainability Strategies for Specific Issues.

Reimbursement

As community paramedicine programs expand the scope of EMS providers, new opportunities for reimbursement may be possible from traditional healthcare payers. Payers are interested in reducing costs, improving care quality, and improving population health. As a result, there has been increased interest in recent years from private and public payers in community paramedicine models that can achieve these goals. Accountable care organizations (ACOs) and other value-based payment models are one way that providers can share in cost savings that result from successful community paramedicine programs.

The Centers for Medicare and Medicaid Services (CMS) developed Emergency Triage, Treat, and Transport (ET3), a five-year, voluntary payment model that allows EMS providers to offer more flexible services to Medicare beneficiaries. For more information about ET3, see Community Paramedicine Models for Reducing Use of Emergency Resources.

According to the National Association of State EMS Officials, state Medicaid agencies in Arizona, Georgia, Minnesota, Nevada, and Wyoming have begun reimbursement for community paramedicine services. Fourteen states provide some reimbursement for treatment without transport. In addition, commercial insurers have launched pilot projects in 17 states to explore payment models for community paramedicine programs.

As more payers begin reimbursing for community paramedicine services, programs will be able to build a sustainable revenue base that supports their work with a variety of patient populations.

Another avenue that may be explored by programs as a potential source of reimbursement to aid in the sustainability of a MIH program would be the use of a community paramedic as a bridge to a formal telemedicine visit with the patient's provider. A clear

reimbursement model has been established for a telemedicine provider visit, but unfortunately many patients may not be able to participate in this type of healthcare encounter due to limited technical resources, internet connectivity, or comfort with the necessary platforms that enable these services. A community paramedic, working with their local healthcare network, may act as an in home facilitator of a formal telemedicine provider visit, not only navigating the technical challenges that may limit a patient's ability to be cared for in this manner, but also increase the clinical evaluation and capabilities of the visit by improving the history gathering, physical exam, and even therapeutic interventions of the telemedicine provider. This type of patient encounter would be reimbursable by most insurance programs by the telemedicine provider, and the local healthcare network may work with the MIH program to help offset costs of the MIH program.

Cost-Sharing with Partners

Because community paramedicine programs by design reduce overall costs to the healthcare system, some local organizations benefiting from the lower costs may be willing to invest in continuing the program. Building these relationships can help community paramedicine programs share scarce resources with rural hospitals, rural health clinics (RHCs), Federally Qualified Health Centers (FQHCs), and other healthcare providers serving rural communities.

To find the right partner, think about the specific services the community paramedicine program is providing and how they might reduce costs or improve outcomes. For example, assisted living facilities may be responsible for costs associated with bringing their residents to and from the hospital. If the community paramedic provides services to residents without requiring a hospital visit, those savings could be used to fund the community paramedicine program while keeping residents more comfortable at home. Similarly, community paramedicine services may reduce hospital readmissions, helping the hospital avoid penalties. Those savings could be invested in continuing the service. Not-for-profit healthcare organizations are also required to have community benefit programs, which might also provide a potential partnership opportunity.

*Taken from https://www.ruralhealthinfo.org/toolkits/community-paramedicine/6/sustainability-strategies

Common Challenges and Barriers (Lessons Learned)

- Securing steady referrals
- Provider Awareness and knowledge regarding the program
    - We don't just need referrals, we need the RIGHT referrals
- Overlapping services in the community
    - How to communicate/coordinate between organizations and resources that have similar goals (different orgs have different, but often overlapping scopes)
    - How to prevent resource overload for the patient

Appendix:

Appendix A: Sample Needs Assessment

Thank you for taking the time to meet with me/us to discuss the upcoming Mobile Integrated Health program. This is a new program that has an overall goal of providing the right care for the right patients in the right place. The City of Lebanon EMS/Fire is partnering with D-H ED/Primary Care/Population Health to develop a program in which paramedics and/or advance EMT personnel provide services to our D-H/APD patients where they live in Lebanon. The goal is to provide health care services in a timely manner to prevent clnical deterioration and avoid unnecessary ED visits, hospital admissions/readmissions, or urgent clinic visits.

In order to create a program that serves the needs of our patients and our care teams, we are interviewing multiple people in the health system and community to understand where there are “gaps in care” that could be filled by this program.

1. What gaps do you see in healthcare for your patients that could be filled by a paramedicine/mobile integrated health team?
2. What are the demographics of the patients most impacted by these gaps?
3. What non-clinical needs are greatest in the population this program will serve?
4. Do you have patients who do not qualify for traditional in home care that could be served by mobile integrated health? What are the characteristics of these patients?
5. Which clinical diseases do you predict would be the most common amongst the patients who would benefit from this program?
6. Do you have patients who frequently use the ambulance and ED? What are the characteristics of these patients?
7. Do you have patients that would benefit from a provider in the home setting to eliminate the need to have a return/follow up visit? What are the characteristics of these patients?
8. Do you have “soft admits” patients you keep in the hospital for an observation because they do not have adequate in home support to be discharged? What are the characteristics of these patients?
9. What ar ethe characteristics of your patients who have the most frequent hospital readmissions?
10. If this program is going to be of value to you, what are the most important factors that need to be included? Example) how to communicate back and forth with paramedics, what skills the paramedic should have, etc.

In development of your needs assessment, consider the following:

- What are the incentives for both partners (community and health system)?
    - Why would Community partners engage in this work?
    - Why would the health system engage in this work?
        - Example)
            - Demonstrating Community Benefit
            - Capture the work that EMS does as a community benefit for the institution
            - Ability to demonstrate in a measurable way what the investments are and outcomes of those investments

Appendix B: Patient Encounters- Smart Phrase Examples

Referral-

Community Paramedic Home Visit Referral - Mobile Integrated Health (MIH) Program
Jeremy Thibeault, EMT-P
City of Lebanon Fire Department
Lebanon, NH 03766
Fax: 603-816-9129
Phone: 603-266-9342

PLEASE ATTACH PATIENT CHART TO THIS MESSAGE

Patient criteria:
- **COVID NEGATIVE ONLY**
- Age 18 years or older
- Resides in City of Lebanon (includes West Lebanon)
- Has established relationship with a DHH provider (Primary or Specialty Clinic)
- Able to participate in their own care (excludes dementia, severe persistent mental health), ***or*** patient has a Caregiver who can be present during the visit
- Will benefit from short-term intervention(s) aimed at an acute condition or exacerbation of a chronic condition
- Not receiving similar services from another organization (ie VNH wound care)

Referral source:
Referring Provider (if not PCP):
Referring Provider's clinic (if not PCP):
PCP (if not referring provider): No primary care provider on file.
PCP clinic location (if not referring provider): FAMILY MEDICINE AT HEATER ROAD

Visits requested:
Expected # of paramedic home visits (max 4): ***
Expected duration (max 4 weeks): ***

All initial visits will include:
- Medication reconciliation and education
- Home safety evaluation
- Social Determinants of Health Screen (food insecurity, transportation, etc)
- Vital signs measurement

Reason(s) for referral (F2 to select check all that apply):

Transitional Care Management
- Date of Admission: ***
- Facility: ***
- Bed (if still admitted):
- Date of Discharge (if discharged):

Skin/Wound Care
Open wound: {Yes/No ***:29856}
Ulcer: {Yes/No ***:29856}
Abscess: {Yes/No ***:29856}
Cellulitis: {Yes/No ***:29856}
On antibiotics: {Yes/No ***:29856}

Assess skin/wound, review dressing changes/wound care, review medications.
Wound photograph requested? : {Yes/No ***:29856}

Respiratory Care
Asthma: {Yes/No ***:29856}
COPD: {Yes/No ***:29856}
Pneumonia: {Yes/No ***:29856}
- Assess work of breathing, lung sounds, O2 sats.
- Review use of medications, spacer, nebulizer.
- Smoking cessation referral if appropriate.

Heart Failure - Weights, use of diuretic, ***
Diabetes/Hypo- Hyper-glycemia ***

Orthopedic Care - Splint/Cast care, pain management, ***
Hydration/Renal - Management of N/V/D, monitoring fluid status, meds, ***
Post-op Care - Wound care, pain management, antibiotics, ***
Allergic Reaction - Symptom management, use of meds and Epi pen, emergency plan, ***
Alcohol Withdrawal - Benzo taper, withdrawal symptoms, ***
Other ***

MIHintakenote - NEW

MIH Community Paramedic Intake Note

Date of referral: [discrete date]

Referral source: [discrete date]:

{single select: DHMC PCP, APD PCP, DHMC ED, APD ED, Cardiology, Pulmonology, Wound Clinic, Post-Op, Other: ***}[discrete data]

PCP: @PCP@
Reason for referral: {use same dropdown list as in .MIHREFERRAL}
Patient currently admitted? {No; Yes – contact by phone; Yes – contact in person}

***

Referral declined by MIH program or patient? {Not declined; Yes – declined by MIH program; Yes – declined by patient} [discrete date]

- If "Yes – by MIH program" then add drop down menu:
  - Reason declined by MIH: {multi-select: Out of area, BH issues, Does not meet clinical criteria; COVID+; Unable to reach patient; Deceased; Other: ***} [discrete date]
  - Date declined: {date field}
- If "Yes – by patient" then add drop down menu:
  - Reason declined by patient: {multi-select: BH issues, MIH services not needed, waiting for VNH, Other: ***} [discrete date]
  - Date declined: {date field}

Date paramedic home visit scheduled for: [discrete date]

Community Paramedic Home Visit Initial Note

Patient:
Date of birth:
MRN:
PCP:

Time spent with patient: [discrete data]

Time spent in Care Coordination: [discrete data]

LFD Run#: [discrete data]

Referral Source: [since this will already entered in the MIHintakenote, might just use a smartlink instead of re-entry??]

{single select: DHMC PCP, APD PCP, DHMC ED, APD ED, Cardiology, Pulmonology, Wound Clinic, Post-Op, Other: ***}[discrete data]

Reason for referral: {use MIH reason for referral list} [discrete data] [since this will already entered in the MIHintakenote, might just use a smartlink instead of re-entry??]

Paramedic response to referring provider and PCP: ***

SUBJECTIVE –

Patient concerns:

Symptoms:

Items on Problem List: [manual, NOT discrete]

Heart failure: Yes/No – Comments:

COPD/Asthma: Yes/No – Comments:

Atrial fibrillation: Yes/ Yes, rate controlled/Yes, uncontrolled rate/No – Comments:

Hypertension: Yes, controlled/Yes, uncontrolled/Yes, borderline control/No – Comments:

Coronary artery disease: Yes/Yes, hx stents or CABG/No – Comments:

Kidney disease: Yes/Yes, last GFR less than 30/Yes, last GFR 30 or greater/No – Comments:

Diabetes: Yes, not on insulin/Yes, on insulin/No – Comments:

Taking anticoagulant (warfarin or DOAC): Yes, warfarin/Yes, DOAC/No – Comments:

Post-op in past 30 days: Yes/No – Comments:

Open wounds: Yes/No – Comments:

Poorly-controlled pain: Yes/No – Comments:

Anxiety or PTSD: Yes/Yes, on medication(s)/Yes, not on medication(s)/No – Comments:

Depression or Bipolar: Yes/Yes, on medication(s)/Yes, not on medication(s)/No – Comments:

Social History: [manual, NOT discrete] –[Can we get Jeremy SER to allow write" of Social Hx?]

Current smoker: {single select: Yes – packs per day: / No}

Alcohol use: {single select: Yes – drinks per week: / No}

OBJECTIVE

BP HR RR Temp Weight [Note: Jeremy can't enter vital]

Notewriter Exam Block?

Best if Jeremy SER allows "write" of Flowsheets:

PHQ-9 at home visit: [enter in Flowsheet; link to flowsheet row for most recent value]

GAD-7 at home visit: [link to flowsheet row]

AUDIT-C: [link to flowsheet row]

SUD-1: [link to flowsheet row – Tim will get more information

Notify PCP Team if PHQ-9 > 12 or GAD-7 > 10

MEDICAL ASSESSMENT & PLAN

#1 –

#2 –

Patient has referral to cardiac and/or pulmonary rehab: {No; Yes – not attending; Yes – attending} [discrete data]

Did MIH recommend referral to CHW?

{Yes; No – Services pending; NO – Already receiving services} [discrete data]

Did MIH recommend referral to Community Nurse?

Yes; No – Services pending; NO – Already receiving services} [discrete data]

Did MIH recommend referral to Pharmacist?

Yes; No – Services pending; NO – Already receiving services} [discrete data]

Follow-up with referring provider is scheduled? {Y/N}

Case closed? {N/Y – select}

- If No, end
- If Yes
  - Date case closed: {date field}[discrete data]
  - Reason case closed {multi-select: hand-off to VNH; hand-off to referring provider; patient no longer interested; deceased; moved outside service area; Other: ***}[discrete data]
  - Patient satisfaction: {single select: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10}[discrete data]

MEDICATION REVIEW

Total # Meds reviewed (including OTC): [discrete data]

Meds taking correctly: [discrete data]

Incorrect meds: prescribed but not taking: [discrete data]

Incorrect meds: taking but not prescribed: [discrete data]

Correct meds, taking incorrectly: [discrete data]

Comments:

PATIENT EDUCATION COMPLETED

Heart failure: Yes/No, - Comment

COPD/Asthma: Yes/No, - Comment

Atrial fibrillation: Yes/No, - Comment

Hypertension: Yes/No, - Comment

Coronary artery disease: Yes/No, - Comment

Kidney disease: Yes/No, - Comment

Diabetes: Yes/No, - Comment

Anticoagulation: Yes/No, - Comment

Post-op care: Yes/No, - Comment

Wound care: Yes/No, - Comment

Pain management: Yes/No, - Comment

Anxiety/Depression: Yes/No, - Comment

SOCIAL DETERMINANTS OF HEALTH SCREENING [SmartForm, discrete data capture]

Recommend PCP make referral to Community Health Worker for concerns about:

Medication availability: Yes/No – Comment

Access to healthcare: Yes/No – Comment

Health Insurance: Yes/No – Comment

Finances: Yes/No – Comment

Housing: Yes/No – Comment

Food: Yes/No – Comment

Utilities (phone, heat, water): Yes/No - Comment

Transportation: Yes/No – Comment

Work/Job training: Yes/No – Comment

Personal safety: Yes/No – Comment

Children/Child care: Yes/No – Comment

Other: Yes/No – Comment

HOME ASSESSMENT

Recommend PCP make referral to Community Health Worker for concerns about:

Heating/Cooling: No concerns/Some concerns/Significant problems – Comment

Plumbing: No concerns/Some concerns/Significant problems – Comment

Electricity: No concerns/Some concerns/Significant problems – Comment

Trip/Fall hazards: No concerns/Some concerns/Significant problems – Comment

Food safety: No concerns/Some concerns/Significant problems – Comment

Mobility/Access (grab bars, ramps, rugs): No concerns/Some concerns/Significant problems – Comment

Mold: No concerns/Some concerns/Significant problems – Comment

Pests: No concerns/Some concerns/Significant problems – Comment

Other:

MIHfollowupnote – NEW (uses SDE from MIHinitialnote)

MIH Community Paramedic Home Visit Follow Up

Patient Name
MRN
DOB
PCP

Time spent with patient: [discrete data]

Time spent in Care Coordination: [discrete data]

LFD Run #: [discrete data]

Number of visits completed: {1, 2, 3, 4, 5, 6, 7, 8, 9, 10}[discrete data]

Subjective

***

Objective

Vital signs

??Notewriter block

Assessment/Plan

***

Medications reviewed? {Y/N}

- If Yes – add the 4 questions about medication review

Did MIH recommend referral to CHW?

{Yes; No – Services pending; NO – Already receiving services} [discrete data]

Did MIH recommend referral to Community Nurse?

Yes; No – Services pending; NO – Already receiving services} [discrete data]

Did MIH recommend referral to Pharmacist?

Yes; No – Services pending; NO – Already receiving services} [discrete data]

Follow-up with referring provider is scheduled? {Y/N}

Case closed? {N/Y – select}

- If No, end
- If Yes
  - Date case closed: {date field}[discrete data]
  - Reason case closed {multi-select: hand-off to VNH; hand-off to referring provider; patient no longer interested; deceased; moved outside service area; Other: ***}[discrete data]
  - Patient satisfaction: {single select: 1, 2, 3, 4, 5, 6, 7, 8, 9, 10}[discrete data]

Community Paramedic Home Visit Progress Note

Patient: @name@
Date of birth: @dob@
MRN: @mrn@
PCP: @pcp@

Referral Source: ***

Reason for referral: ***

Paramedic response to referring provider and PCP:

***

Recent TCM Information:

@tcminfo@

SUBJECTIVE – please format headers w outline (use 1x1 Table) and blue fill

Summary of events:

***

Patient concerns:

***

Symptoms:

***

Items on Problem List: [SmartForm, do NOT need discrete data]

Heart failure: Yes/No – and boxes for Comments and to enter # value for “Estimated dry weight”

COPD/Asthma: Yes/No -- and Comment box

Atrial fibrillation: Yes/ Yes, rate controlled/Yes, uncontrolled rate/No -- and Comment box

Hypertension: Yes, controlled/Yes, uncontrolled/Yes, borderline control/No -- and Comment box

Coronary artery disease: Yes/Yes, hx stents or CABG/No -- and Comment box

Kidney disease: Yes/Yes, last GFR less than 30/Yes, last GFR 30 or greater/No -- and Comment box Diabetes: Yes, not on insulin/Yes, on insulin/No -- and Comment box

Taking anticoagulant (warfarin or DOAC): Yes, warfarin/Yes, DOAC/No -- and Comment box

Post-op in past 30 days: Yes/No -- and Comment box

Open wounds: Yes/No -- and Comment box

Poorly-controlled pain: Yes/No -- and Comment box

Anxiety or PTSD: Yes/Yes, on medication(s)/Yes, not on medication(s)/No -- and Comment box

Depression or Bipolar: Yes/Yes, on medication(s)/Yes, not on medication(s)/No -- and Comment box

Social History:

@soch@ [I think that is the short hx with alcohol, tobacco, drug use]

OBJECTIVE

@vs@

@bmie@

@physexam@ [standard adult Notewriter SmartBlock]

PHQ-9 at home visit:

GAD-7 at home visit:

MEDICAL ASSESSMENT & PLAN

#1 – ***

#2 – ***

MEDICATION REVIEW [SmartForm, discrete data capture]

Meds reviewed (including OTC): # and comment box

Incorrect meds: prescribed but not taking: # and comment box

Incorrect meds: taking but not prescribed: # and comment box

Correct meds, taking incorrectly: # and comment

Comments:

PATIENT EDUCATION COMPLETED [SmartForm, discrete data capture]

Heart failure: Yes/No, Comment box

COPD/Asthma: Yes/No, Comment box

Atrial fibrillation: Yes/No, Comment box

Hypertension: Yes/No, Comment box

Coronary artery disease: Yes/No, Comment box

Kidney disease: Yes/No, Comment box

Diabetes: Yes/No, Comment box

Anticoagulation: Yes/No, Comment box

Post-op care: Yes/No, Comment box

Wound care: Yes/No, Comment box

Pain management: Yes/No, Comment box

Anxiety/Depression: Yes/No, Comment box

SOCIAL DETERMINANTS OF HEALTH SCREENING [SmartForm, discrete data capture]

Referred to Community Health Worker for concerns about:

Medication availability: Yes/No – and comment box

Access to healthcare: Yes/No – and comment box

Health Insurance: Yes/No – and comment box

Finances: Yes/No – and comment box

Housing: Yes/No – and comment box

Food: Yes/No – and comment box

Utilities (phone, heat, water): Yes/No – and comment box

Transportation: Yes/No – and comment box

Work/Job training: Yes/No – and comment box

Personal safety: Yes/No – and comment box

Children/Child care: Yes/No – and comment box

Other: Yes/No – and comment box

HOME ASSESSMENT [SmartForm, discrete data capture]

Heating/Cooling: No concerns/Some concerns/Significant problems – and comment box

Plumbing: No concerns/Some concerns/Significant problems – and comment box

Electricity: No concerns/Some concerns/Significant problems – and comment box

Trip/Fall hazards: No concerns/Some concerns/Significant problems – and comment box

Food safety: No concerns/Some concerns/Significant problems – and comment box

Mobility/Access (grab bars, ramps): No concerns/Some concerns/Significant problems – and comment box

Mold: No concerns/Some concerns/Significant problems – and comment box

Pests: No concerns/Some concerns/Significant problems – and comment box

Other: comment box

Appendix C: Project Plan

#	Task Description
1	**Administrative**
1.01	Finalize MIH section of PILOT
1.02	Draft NH MIH application
1.03	Post .5 FTE Project Coordiantor (D-H)
1.04	Affiliation agreement for MIH staff to shadow/work in D-H Clinics (mirror EMS student process)
1.05	Patient consent (D-H Connect and
2	**Project Infrastructure**
2.01	Complete Charter
2.02	Define initial project scope and patient population
2.03	Finalize AIM
2.04	Establish operational working team (APD, Patient, Finance, Lebanon Community Nurse)
2.05	Establish Community Advisory Workgroup (to meet 2-3xs/year)
2.06	Establish Behavioral Health referral process
2.06	Determine tracking process for community based referals (pre-Unite Us) look at CHW pathways (Tempsis to start)
3	**EMS Staffing and Training**
3.01	MIH Position posted
3.02	Define training, develop curriculum
3.03	Interview
3.04	Onboarding
3.05	Setup clinical rotation schedule
4	**Medical record documentation**
4.01	Access effectiveness of mirroring Community Nurse access, D-H Connect
4.02	Define Paramedic scope of work to inform eDH or D-H connect access
4.03	Access need for patient consent
4.04	Establish referral process to Community Paramedic
4.05	Establish point of contacts for medical control questions (like EMS control). Tele ED docs at D-H can work as medical control, if not a specialty referral.
5	**Communications**
5.01	Identify partners and referral sources (letter out)
5.02	Meeting with partners and initial referral sources (stakeholders)
5.03	Roster with short bio with planning team, partners and staff
5.04	Regular email updates to partners
5.05	Communications to City of Lebanon
5.06	Brand the program MIH and Community Nurse, name and logo. D-H communications approval
6	**Data**
6.01	Needs assessment D-H, LFD and partners
6.02	Patient interviews
6.03	Create data collection plan

Appendix D: Community Paramedic Job Description

Position Title: Career Firefighter-Mobile Integrated Health Care

STATEMENT OF DUTIES

This class of Firefighter is responsible for performing, maintaining, and updating a wide range of technical skills relating to fire prevention, life safety education, suppression, rescue, emergency medical services, hazardous materials operation, and related activities. The Firefighter performs these skills and exercises some supervision in the physically, emotionally, and mentally demanding environments of emergency response and to a lesser degree in the day-to-day operation, collateral duties, maintenance and training of the fire service profession. ***Specifically, this position functions as a member of a healthcare team providing assessment and care to patients within the scope of the Mobile Integrated Healthcare Program.***

SUPERVISION RECEIVED

Incumbent works as directed or assigned, the incumbent provides direct supervision and is responsible for all subordinates assigned. With no officer present, as the senior firefighter present at an emergency scene will take command until relieved by an officer. The incumbent may have regularly assigned tasks and duties in which considerable independence and initiative is exercised. With respect to assigned collateral duties, the incumbent may exercise supervision of LFD team members and budgetary issues specific to the assigned duty.

SUPERVISION EXERCISED

Incumbent works as a Firefighter/Advanced EMT or Paramedic under the direct supervision of the Fire Chief or his/her designee. The incumbents will carry out the lawful orders and directions given by any LFD officer. During emergency responses, the incumbent is supervised in accordance with the Incident Command System as needed.

JOB ENVIRONMENT

Position responsibilities requires good judgment, communication, and initiative in interpreting orders, rules, regulations, and procedures, performing assigned collateral duties and in handling emergency situations. The position should exercise independence of judgment and action while a senior member in an emergency. When acting as senior member, the position provides direct or general supervision over assigned shift personnel and is responsible for their safety until relieved of duties.

POSITION FUNCTIONS

The essential functions or duties listed below are intended only as illustration of the various types of work that may be performed. The omission of specific statements of duties does not exclude them from the position if work is similar, related, or a logical assignment to the position.

Essential Functions

Mobile Integrated Healthcare Specific Functions

1. Work with department administration and DHMC leadership to develop the operational plan and scope of practice for the City of Lebanon-DHMC Mobile Integrated Health Care Program (MIH).
2. Identifies patient's needs and assists in connecting patients with available community and medical resources.
3. Research, contacts, and schedules appointments for patient enrolled in the Lebanon Mobile Integrated Health Care Program.
4. Responds to scheduled appointments with patients, follows established procedures for patient intake and follow up.
5. Provide appropriate documentation of assessment, care provided, and plan of care.
6. Participate in on-going professional development by maintaining continuing education hours as required.
7. Works in cooperation with the Lebanon Community Nurse to implement the MIH Operational Plan.
8. Responds to emergency calls as needed.

Firefighter-Paramedic or AEMT

1. Responds to emergency and non-emergency calls. Receives supervision through the chain of command or the Incident Command System. If the Firefighter is the senior member on scene, will assume command, evaluate the situation, do initial size up, make technical decisions for controlling the emergency, direct apparatus, read, assimilate, interpret and act upon information contained in pre-plan books, hazardous materials manuals and other technical resources. Assign personnel and equipment as needed and continue until relieved by a more senior member.

2. Performs routine maintenance and basic trouble shooting on LFD facilities apparatus and equipment as assigned.

3. Performs, as assigned, clerical duties including making our reports, roll calls, vehicle maintenance reports, and any other reports prescribed by LFD.

4. Performs, under supervision, fire prevention inspections; indoctrinates the public on

fire safety and emergency life rescue. Reporting noted or known violations to the supervisor and participates in pre-fire planning activities.

5. Instructs subordinates, as assigned, in the operation of a variety of firefighting vehicles, tools, power equipment, emergency medical equipment, and other related firefighting and rescue equipment.

6. Able to drive and operate all LFD motorized fire apparatus. Able to operate, identify safety/operational parameters for all LFD equipment. Performs daily chores and apparatus weekly and daily checks, assures that assigned apparatus and equipment is in condition for emergency response as the assigned operator is responsible for the response readiness of the apparatus assigned and its equipment

7. Functions at the minimum EMS Certification of Advanced EMT maintaining, upgrading, and performing required medical services as directed or required. May be responsible for advanced levels of care, following State EMS and Hospital emergency medical protocols.

8. Performs other related duties as required.

RECOMMENDED MINIMUM QUALIFICATIONS

Physical and Mental Requirements

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the position's essential functions.

The incumbent is exposed to a difficult work environment, in most cases characterized by a moderately noisy office setting, but during an emergency the incumbent must respond, and at that time the incumbent could be faced with any number of hazards. Due to the nature of the environment, it is difficult to predict hazards. Generally, works in extreme temperatures with protective gear weighting in excess of 50 pounds. The incumbent is exposed to high places, toxic or caustic chemicals, near moving or mechanic parts, is exposed to risk of electric shock, risk of radiation, infectious disease, and stress up to1/3 of the time; outdoor weather conditions, fumes, or airborne particle, or the extremes of heat/cold up to 2/3 of the time. The incumbent is exposed to occupational risks typical of a firefighter, working alongside said members as necessary in a small department as well as tending to administrative requirements. These risks include the products of combustion, infectious disease exposure, fall hazards, entrapment, atmospheric and products hazards, life safety exposure, and heavy equipment hazards.

The incumbent is required to sit, stoop, kneel, crouch or crawl, and reach with hands and arms up to 1/3 of the time; to stand, walk, climb or balance, be exposed to stress and emotional demands up to 2/3 of the time; and talk or listen/hear, or use hands more than 2/3 of the time. The incumbent frequently lifts and carries a minimum of 45 pounds and must be able to collectively lift, carry, and balance patients weighing in excess of 100 pounds.

Equipment operated includes trucks in excess of 26,001 lbs., light trucks, automobile, heavy and light equipment, medical equipment, pneumatic tools, power and hand tools, office machines, computers, and emergency vehicles/special emergency equipment. Equipment includes extrication equipment: rams, cutters, spreaders, air bags, hydraulic jacks; air sampling equipment: multi-gas meters; heights rescue equipment: ropes, harnesses, slings, baskets; water rescue equipment: cold water suits, boat, outboard, life jackets; and a variety of other equipment including: phones, calculators, pens, pencils, flashlights, radios, aerial ladders, positive pressure ventilation fans, portable pumps, main pumping engines, reference books, technical manuals ,the Internet, cameo, and cameras.

Education and Experience

A candidate for this position should have a high school diploma or equivalent. Must be able to meet the hiring requirements as outlined New Hampshire Fire Standards and Training administrative rules. Must be able to successfully complete pre-employment physical. Must possess or be able to acquire within three (3) months of date of hire, a valid driver's license to operate motorized fire apparatus.

Must be able to complete New Hampshire Certified Firefighters Level II within one (1) year from date of hire.

Possess a minimum Certification as an Advanced EMT (Paramedic preferred)

It is assumed by the LFD that applicants and new members have no working knowledge of the LFD. The Firefighter is expected to gain the required knowledge in a efficient and timely manner. Along with Firefighter Level II Certification within one (1) year, the Firefighter will have a good basic knowledge of the workings of the fire service and the LFD as outlined in this document.

Knowledge, Skills and Abilities

A candidate for this position should have knowledge, skills and ability of a Firefighter and Certified Advanced EMT or Paramedic. Ability to react calmly and quickly under duress and strain. Considerable knowledge of modern emergency services operations and techniques, customer service and awareness, basic computer skills, hazardous material procedures, street and hydrant locations, high hazard occupancies and Fire Department apparatus and equipment. The ability to use, maintain and enhance base knowledge. Ability to communicate both verbally and in writing in the preparation of report, records, memos, and the like. Considerable mechanical aptitude and knowledge of the maintenance of equipment. Thorough knowledge of LFD standing orders, directives, and standard operating procedures. Ability to proficiently operate motorized fire apparatus.

Appendix E: Slide Deck

Dartmouth Health

Department of Population Health
DARTMOUTH HITCHCOCK MEDICAL CENTER

Lebanon Fire Department
Dartmouth Health
Mobile Integrated Health: Community Paramedic Program

February 15, 2022

Lebanon Fire Department
Dartmouth Health
Mobile Integrated Health: Community Paramedic Program

A collaboration between Dartmouth Hitchcock Medical Center and the City of Lebanon

Healthcare in the comfort of your home

Right person, right care, right place, right time.

- Extension of the existing collaborations between the healthcare system and community organizations for a coordinated system of care.

- National Rural Health Association " an organized system of services based on local need, which are provided by EMS and paramedics integrated into the local or regional health care system and overseen by emergency and primary care physicians."

Mobile Integrated Health
Dartmouth Health

Patient Story: Cathy

Clinical
- NEW DX of DM
- RECENT STROKE
- other chronic diseases
- legally blind

Socioeconomic
- fixed income
- Medicare supplemental
- good health literacy

Tech
- has access to tech
- needs some assistance w new tech

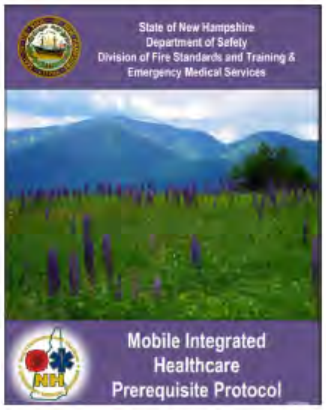
Support
- some friends but they work during day
- alone during the day
- no family in area
- transportation barrier

Level of Engagement/Barriers
- open to support
- invested in her care
- lacks knowledge about new meds

Mobile Integrated Health
Healthcare in the comfort of your home
Dartmouth Health

Medical Oversight

- MIH programs in NH must be approval by the NH Department of Safety Division of Fire Standards and Training & EMS
- Medical direction is required from both the agency's EMS Medical Director as well as a primary care medical director



Mobile Integrated Health
Healthcare in the comfort of your home
Dartmouth Health

Medical Oversight

- This combination of medical direction allows the program to leverage prehospital resources and experience with the acute care resources of the ED/hospital as well as chronic disease management expertise of clinic based assets
- Training / experience / expertise of medical directors complement each other

Medical Oversight

- Medical directors will work together to provide
  - Education and clinical experience for MIH providers
  - Protocol development
  - Standards of evaluation / management / documentation
  - Quality management program
  - Assurance of appropriateness of enrolled patients
  - Evaluation of continued enrollment in program

Medical Oversight

- Communication between our community paramedic with referring providers and specialty clinics to occur through Epic for routine questions and support
- Immediate online medical control to be delivered through phone consultation with
  - Specialty clinics
  - DHMC TeleED physicians (video support being developed)
  - Program medical directors

Mobile Integrated Health
Healthcare in the comfort of your home
Dartmouth Health

Education

- Educational curriculum developed to fill in knowledge gaps looking at:
  - Community based needs
  - Interdisciplinary collaboration
  - Patient centric care
  - Community paramedic wellness and safety
  - Preventative care and education for patients
  - Ethical and legal considerations
- Didactics, self study, case based discussions, and clinical time
  - Care management
  - Geriatric ED program
  - Specialty clinics (CHF, COPD, Wound Care)
  - VNA

Mobile Integrated Health
Healthcare in the comfort of your home
Dartmouth Health

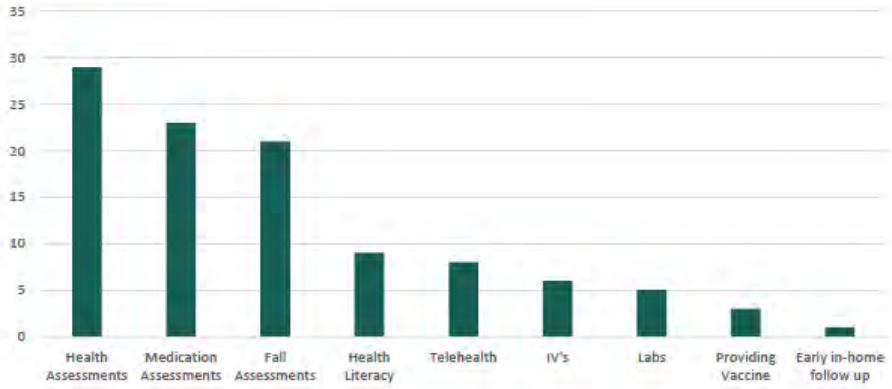
Meet our Community Paramedic

Jeremy Thibeault

Mobile Integrated Health
Healthcare in the comfort of your home
Dartmouth Health

Assessment data

Potential interventions

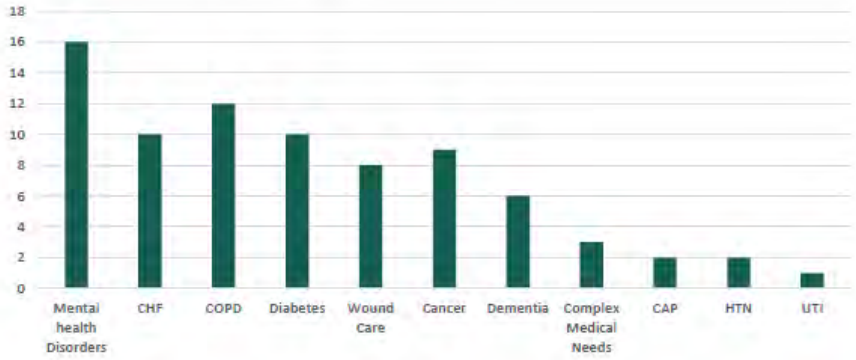


N=35

Mobile Integrated Health
Healthcare in the comfort of your home
Dartmouth Health

Assessment data

Medical conditions identified

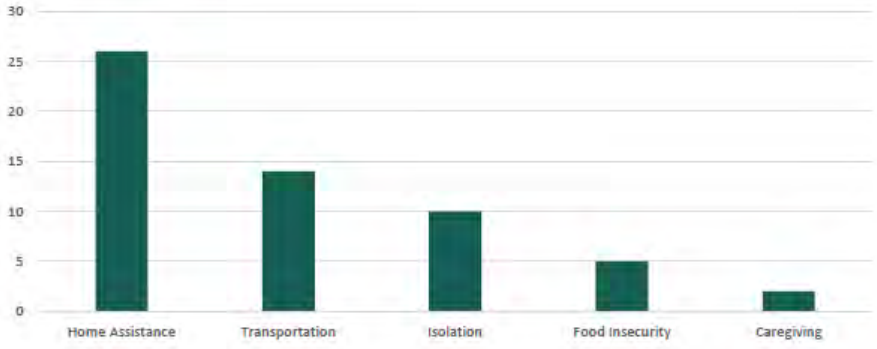


N=35

Mobile Integrated Health
Healthcare in the comfort of your home
Dartmouth Health

Data Assessment:

Non-medical needs



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Mobile Integrated Health
Healthcare in the comfort of your home
Dartmouth Health

Program Goals

Quadruple AIM

Mobile Integrated Health
Healthcare in the comfort of your home
Dartmouth Health

Pilot Referral Process

- Patients 18+ years old
- Live in the Lebanon Fire Department response area
- Phase 1: DHH Family Medicine and General Internal Medicine
  - Heater Road, 3M, Lyme, APD
- Phase 2: DHH Emergency Department or Specialty Clinics:
  - Wound, COPD, Heart Failure

MIH Team will notify clinics once referrals are open and train on how to place referrals

Mobile Integrated Health
Healthcare in the comfort of your home
Dartmouth Health

Appendix F: Patient Brochure

ABOUT OUR PARTNERHSIP

Lebanon Fire Department/Dartmouth-Hitchcock Mobile Integrated Health is a collaboration between these two organizations to provide health services in the patient's home by a trained community paramedic.

This program operates under the medical oversight of D-H Emergency and Primary Care physicians, in collaboration with D-H providers

The community paramedic operates with the goals of:

- Preventing unnecessary emergency medical transports and emergency room visits;
- Following up with patients after hospital discharge;
- Preventing hospital admissions/readmissions;
- Improving the overall health of our patients

CONTACT US

For more information, please email MIH@lebanonnh.gov

For Provider referrals, please send eDH In Basket Message to Jeremy Thibeault using **.MIHReferral**

LEBANON FIRE DEPARTMENT/ DARTMOUTH-HITCHCOCK MOBILE INTEGRATED HEALTH

Healthcare in the comfort of your home

Mobile Integrated Health
Healthcare in the comfort of your home
Dartmouth-Hitchcock

IS A VISIT FROM THE COMMUNITY PARAMEDIC RIGHT FOR YOU?

The Community Paramedic works directly with your doctor. They can provide non-emergency services in your home.

The Community Paramedic can assist with:

- Transitions home from the hospital/emergency department
- Checking medications
- Managing health needs and coordinating care at home

WHO CAN BE SEEN BY THE COMMUNITY PARAMEDIC

The Lebanon Community Paramedic serves patients living in Lebanon and West Lebanon, NH with a referral from a Dartmouth-Hitchcock Health provider.

This includes: Dartmouth-Hitchcock Medical Center, Alice Peck Day and other D-H affiliate hospitals

If you are interested in having a visit with the Lebanon community paramedic you should talk with your D-H provider

WHO IS ELIGIBLE

THIS PROGRAM IS FOR PATIENTS WHO MEET THE FOLLOWING CRITERIA:

- Age 18 years or older
- Resides in City of Lebanon (includes West Lebanon)
- Has established relationship with a Dartmouth-Hitchcock Health (D-HH) provider (Primary or Specialty Clinic)
- Able to participate in their own care (excludes dementia, severe persistent mental health), **or** patient has a Caregiver who can be present during visits
- Will benefit from short-term medical intervention(s) aimed at an acute condition or exacerbation of a chronic condition
- Not receiving similar services from another organization (vising nurse and hospice)

RIGHT PERSON, RIGHT CARE, RIGHT PLACE, RIGHT TIME

COMMUNITY PARAMEDIC SERVICES PROVIDED:

- Care Transitions
- Chronic Disease Support
- Wound Care
- Monitoring Vital SIgns
- Medication Reconciliation
- Home Safety Evaluations

AND OTHER INTERVENTIONS WITHIN PARAMEDIC SCOPE OF PRACTICE

Mobile Integrated Health
Healthcare in the comfort of your home
Dartmouth-Hitchcock

COORDINATED AND CONNECTED

- Access to the electronic medical record allows the community paramedic to report information (such as changes in health status etc.) back to D-HH providers
- Working in conjunction with D-HH providers, the community paramedic is able to follow medical orders, providing care in the patients home and avoiding high cost settings
- **Note:** Community paramedic services are not intended to replace regular clinic visits

HOW TO REFER

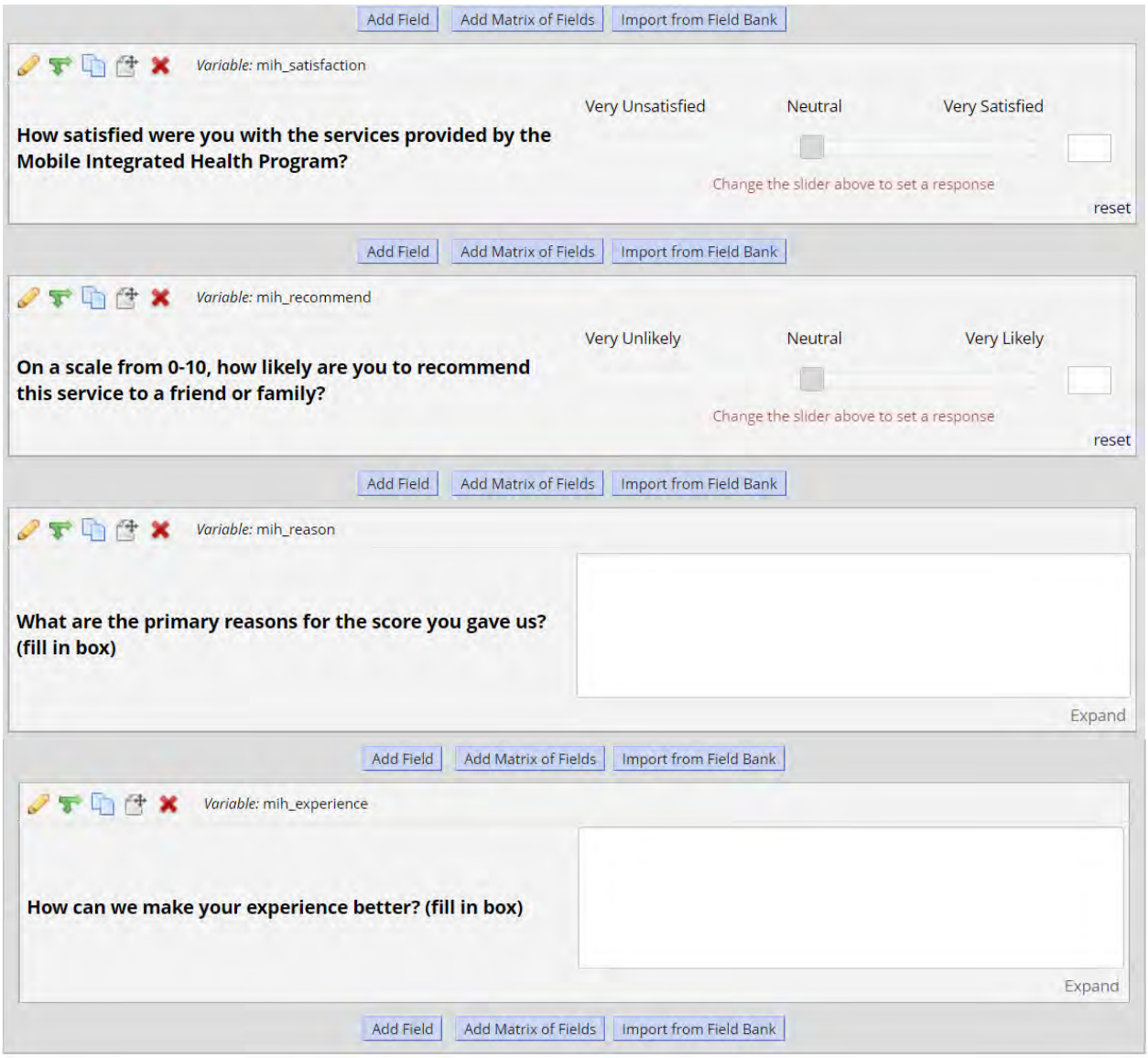
Referrals for the community paramedic program must come from a D-H provider

Send an in basket message to "Jeremy Thibeault" including **.MIHReferral**

Appendix G: Patient Satisfaction Survey

Community Paramedic records patient MRN and hands iPad to patient to complete the survey.

Decision: We only request patient satisfaction surveys from patients with planned discharge; patients who need escalated care and who do NOT “complete the program” with the community paramedic are not asked to complete the patient satisfaction survey



Appendix H: Fire Department Survey

Please select the option that best describes your role:

If other, please enter your role here:

It was easy to refer my patient to the Lebanon Community Paramedic program

- Disagree
- Somewhat disagree
- Neither agree or disagree
- Agree
- Strongly agree
- Unsure/ NA

reset

After referral to the community paramedic, my patient received services in a timely manner

- Disagree
- Somewhat disagree
- Neither agree or disagree
- Agree
- Strongly agree
- Unsure/ NA

reset

The care provided by the Community Paramedic met my expectations

- Disagree
- Somewhat disagree
- Neither agree or disagree
- Agree
- Strongly agree
- Unsure/ NA

reset

This program has positively impacted the department's readiness for emergency response.

- Disagree
- Somewhat disagree
- Neither agree or disagree
- Agree
- Strongly agree
- Unsure/ NA

reset

This program has reduced nonemergent requests for assistance to the fire department.

- Disagree
- Somewhat disagree
- Neither agree or disagree
- Agree
- Strongly agree
- Unsure/ NA

reset

This program has improved the overall health of the community.

- Disagree
- Somewhat disagree
- Neither agree or disagree
- Agree
- Strongly agree
- Unsure/ NA

reset

I will refer additional patients to the Lebanon Community Paramedic program

- Disagree
- Somewhat disagree
- Neither agree or disagree
- Agree
- Strongly agree
- Unsure/ NA

reset

Additional comments or recommendations:

Expand

Additional Resources:

Communication example introducing program to providers:

To: D-H Lebanon and APD Physicians, Advanced Practice Providers, Residents and Fellows

From: Sally A. Kraft, MD, MPH, Vice President, Population Health

Timothy E. Burdick, MD, Primary Care

Thomas W. Trimarco, MD, Emergency Services

Date: Tuesday, December 14, 2021

Re: Lebanon Fire Department/Dartmouth-Hitchcock Mobile Integrated Health Program

Colleagues,

We are pleased to announce a novel collaboration between the Lebanon Fire Department and Dartmouth-Hitchcock Health aimed to provide health services to patients who would benefit from care provided in the comfort of their own homes. The Mobile Integrated Health Program is a new service for D-HH patients who live in Lebanon and have an established relationship with a D-HH provider and do not qualify for other at-home services. Through this program, a trained paramedic from the Lebanon Fire Department, operating under the medical oversite of D-HH Emergency and Primary Care physicians, delivers care with the goals of:

- Preventing unnecessary emergency medical transports and emergency room visits
- Following up with patients after hospital or emergency department discharge
- Preventing hospital admissions/readmissions
- Improving the overall health of our patients

While not intended to replace regular clinic visits, the paramedic works in partnership with D-HH providers following medical orders to, provide at-home care and to report any changes in the patient's health status. Services include:

- Support during care transitions
- Chronic disease support
- Wound care
- Monitoring vital signs
- Medication reconciliation
- Home safety evaluations
- Other interventions within paramedic scope of practice

We are excited to introduce Jeremy Thibeault, a paramedic with the Lebanon Fire Department, in his new role as the MIH community-based paramedic. Jeremy has joined this program with over 20 years of experience as a paramedic and has received additional training with D-HH experts to prepare for this role.

The Mobile Integrated Health Program is available to patients who meet the following criteria:

- Age 18 and older
- Resides in the city of Lebanon (including West Lebanon)

- Has an established relationship with a D-HH primary or specialty provider
- Is able to participate in their own care or has a caregiver available for assistance (the program excludes dementia and other severe persistent mental health diagnoses)
- May benefit from short-term medical intervention aimed at managing an acute condition, transitions in care, or exacerbation of a chronic condition
- Is not receiving similar services from another organization (such as visiting nurse or hospice)

Referrals must come from a D-HH provider. To make a referral, please send an eD-H In-Basket message to Jeremy Thibeault using .MIHReferral (see full instructions below). Jeremy will document the care he provides in eD-H, coordinating services and maintaining communication with referring providers through eD-H and verbally as needed.

This pilot program supports our goal to deliver the right care, to the right patient, in the right place, at the right time. We hope this program will prove to be a valuable service for our patients and an important addition to our healthcare teams.

Questions about the program can be directed to one of us or MIH@lebanonnh.gov.

Documentation and Communication in the Health System's EMR

Legal Approval

07/26/2021

Hi Mary Beth-

I am reaching out to follow up on the conversation that you were a part of several weeks regarding EPIC access for the DHMC-Lebanon Fire Department Mobile Integrated Healthcare project. As we get closer to a go live date, we are working on trying to develop referral processes, documentation standards, and communication procedures. All of this is dependent on what type of EPIC access our LFD colleagues will have for this work. I was hoping that you and your group have been able to review our request for granting read/write access to this unique joint program, and may be able to provide us with an answer, or if we could discuss more to answer any further questions you may have.

I know this is a unique situation that does not fall under our normal operations, but believe there are multiple reasons why this request is reasonable:

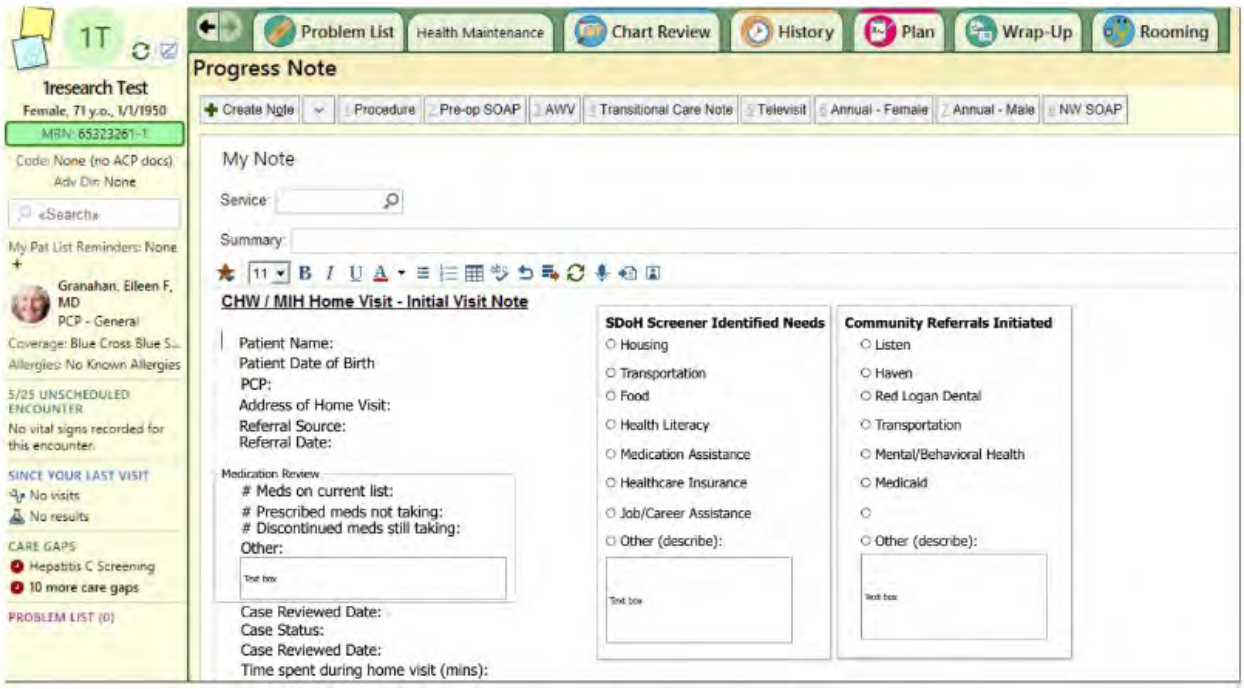
- The medical care provided under this program will be based on DHH providers' orders, and will be under the oversight of the DHMC Medical Direction Team (myself and Dr. Tim Burdick) and the ordering provider. LFD will be following DHMC provider orders, treatment protocols, etc specifically developed for this program. As DHMC is ultimately responsible for assurance of the quality of the medical care provided, clear and timely communication and consistent documentation of ongoing care and interactions are essential to assure safe, high quality care.
- LFD providers will be training with our specialty clinics, and our providers, learning their documentation standards, and adhering to their established note templates. Being able to continue the consistent documentation standards that patients receive will aid the specialty clinics and PCPs in their tracking and ongoing care of the patients they enroll in the program.

- This program is funded by DHMC. We provide the salary and equipment support for LFD to complete this work, and will do so for the foreseeable future. It is in the financial best interest of the institution to be able to make this program as user friendly and successful as possible.
- Being able to utilize EPIC for referrals, communication, and report writing will encourage the use of the program by DHH programs, align it with other existing processes for referrals, and allow us to accurately track the efforts, effects, and outcomes of the patients and DHH service lines utilizing the program.

I welcome to possibility to discuss this further with you and your team if needed. We appreciate your efforts and thoughtful consideration, and I look forward to hearing back from you.

Tom

8/18/2021

Kim is reviewing the regulations related to the NH program (so it will be helpful for our toolkit to be able to comment that NH regulations permit do not inhibit paramedics to access health system records). She wanted to know who was supervising the paramedic, under whose medical orders is the paramedic working, which doctor(s) (Tom and Tim) are responsible for quality assurance for the program. ...

Creating Clinical Documentation Templates