
# Alabama Office of EMS

## Operational Guidelines

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## Scope of Practice
## 18.01

Licensed Emergency Medical Services Personnel (EMSP) are authorized to perform procedures and administer medications as defined by the protocols. Each level of EMSP, as defined by the EMS Rules, has a specific list of authorized procedures and medications as defined by that level's scope of practice.

EMSP are prohibited from performing any procedure or utilizing any medication not approved by the State Board of Health even though they may have been taught these medications and procedures in their EMSP curriculum. This does not include medications that may be utilized by a Paramedic as directed by a physician during a patient transfer. Specific instructions should be obtained regarding the administration and maintenance of the medication.

Lower level EMSP can assist a higher level EMSP with patient care activities, as long as the lower level EMSP does not exceed his/her Scope of Practice regarding administration of medications or performance of procedures. Ultimately, the higher level EMSP is responsible for patient care and documentation.

## Communications
## 18.02

**Notify Alabama Trauma Communications Center (ATCC) when appropriate before leaving the scene to determine ATCC routing or hospital divert status for the final patient destination.**

**ATCC contact number:**

**1-800-359-0123**

**Notify the receiving hospital as soon as possible when transporting to that facility.**

**Call On-Line Medical Direction (OLMD):**

- If in doubt as to protocol or procedure needed.
- If an EMSP needs patient care advice.
- In order to gain approval to cease resusitative measures once those measures have been initiated.

# Death in the Field
# 18.03

**WITHHOLDING RESUSCITATIVE EFFORTS**

1. Determining death in the field (DIF) without initiating resuscitative efforts should be considered under any of the following conditions:
    a. Decapitation.
    b. Massive crush injury or evisceration of the heart, lung, or brain.
    c. Incineration.
    d. Rigor Mortis in a warm environment.
    e. Venous pooling in dependent body parts (dependent lividity).
    f. Decomposition.
    g. Patient qualifies as a "DNAR" patient.
    h. A pulseless, apneic patient in a mass casualty incident, multiple-patient scene, where the resources of the system are required for the stabilization of living patients.
    i. A victim of blunt trauma with no vital signs in the field.
2. OLMD must be contacted and must confirm the withholding of resuscitative efforts if resuscitative measures are initiated.
3. If the patient is declared dead on scene, the body must not be moved until the proper authority (such as law enforcement agencies, the coroner, the medical examiner, or their designee), has been notified (if not already on scene), and they agree to the movement of the body.
4. An ECG is not required and OLMD does not have to be contacted for determining DIF when obvious signs occur as noted above. This must be clearly documented.

**TRAUMATIC CARDIAC ARREST SPECIAL CONSIDERATIONS**

1. In deaths from blunt trauma, a monitor is not necessary to use in initial assessment of the patient unless the paramedic doubts death has occurred. If the monitor is used, only a sustained and recognizable QRS of at least forty (40) per minute should be considered compatible with life in these trauma patients.
2. In cases of penetrating torso injury with no vital signs in the field, OLMD should be contacted immediately. OLMD can determine whether to continue resuscitative efforts.
3. If OLMD stops resuscitation during transport, the patient must be taken to that OLMD physician to be pronounced dead. In some circumstances, OLMD may not be working in the receiving facility. If the OLMD is not at the receiving facility and resuscitation is terminated during transport, you must notify the receiving facility as soon as possible. EMSPs do not pronounce patients in the field and a time of death is not obtained, only a time of ceasing resusitative efforts for documentation purposes.

**DETERMINING DEATH IN CARDIAC MEDICAL ARREST**

1. Cardiopulmonary resuscitation and advanced life support may be terminated by prehospital personnel if all of the following criteria are met:
    a. Patient is in cardiac arrest at the time of arrival of advanced life support.
    b. Appropriate full advanced life support procedures, including Advanced Airway placement, are performed for 20 minutes with no spontaneous pulse, and no evidence of neurologic function, unless earlier termination is appropriate as determined by OLMD.
    c. OLMD approves termination of efforts.
    d. If OLMD stops resuscitation during transport, the patient must be taken to that OLMD physician to be pronounced dead. In some circumstances, OLMD may not be working in the receiving facility. If the OLMD is not at the receiving facility and resuscitation is terminated during transport, you must notify the receiving facility as soon as possible.
    e. If the patient is declared dead on scene, the body must not be moved until the proper authority (such as law enforcement agencies, the coroner, the medical examiner, or their designee), has been notified (if not already on scene), and they agree to the movement of the body.
2. All patients in Ventricular Fibrillation should, in general, have full resuscitation continued and be transported, except when DNAR or other withholding resuscitative efforts apply. If in doubt, contact OLMD.
3. Termination will not be considered in any of the following circumstances:
    a. Patients with persistent ventricular fibrillation or pulseless ventricular tachycardia.
    b. Patients who have return of spontaneous pulse at any time during the resuscitative effort.
    c. Patients who exhibit neurologic function.
    d. Patients who arrest after the arrival of advanced life support.

**DOCUMENTATION**

1. All patient care provided should be documented with procedure and time.
2. In non-traumatic deaths, all non-resuscitation or stopped resuscitation cases should have an ECG rhythm strip that shows the patient's rhythm unless the patient shows obvious signs of death.
3. All conversations with physicians should be fully documented with physician's name, times, and instructions.

If resuscitation is withheld on scene, and the coroner or medical examiner is not coming to the scene, if possible, obtain name and address of the deceased, name, address, and phone number of a family member, and name and phone number of patient's private physician.

# Documentation of Care
## 18.04

In Reference to 420-2-1-.21

1. Each EMS provider shall ensure that an accurate and complete electronic patient care report is completed on every dispatched incident within 24 hours.
2. The incident report shall be submitted to the AL EMSIS database within 72 hours of the call completion time.
3. An accurate and complete patient care report, as required by the EMS rules, shall be provided to the patient receiving facility upon delivery of the patient or as soon as practical. In no instance should delivery of the patient care report to the facility exceed 24 hours.

# Portable Physician Do Not Attempt Resuscitation Order (DNAR)
# &
# Pediatric Palliative and End of Life (PPEL)
# 18.05

In Reference to 420-2-1-.04

The goal is to provide comfort and emotional support with the highest quality medical care to patients in conformity with the highest ethical and medical standards. Unless a "DNAR" or "PPEL" order is issued, any patient who sustains a cardiopulmonary arrest will receive full cardiopulmonary resuscitation with the objective of restoring life. If a DNAR order has been issued, the family may countermand that order and request that resuscitation be attempted.

Please refer to Rule 420-2-1-.04 for further information. **If there is any question about a DNAR order, contact OLMD.**

# Medical Management of the Scene
# 18.06

1. The highest level EMSP on the first arriving ALS unit will assume responsibility for directing overall patient care and will continue this function unless relieved by the responding jurisdiction's personnel. The responding jurisdiction's personnel must be authorized for such responsibilities by local, city, county, district ordinances or legislative acts, or must have been dispatched by the recognized dispatch agency. These personnel must also be of equal or higher EMSP license level.

2. When a medical professional is at the scene of an emergency he or she may provide assistance and shall be treated with professional courtesy. If the medical professional offers their assistance at the scene, they should be asked to identify themselves and their level of training and the EMSP should contact OLMD for further guidance if there are uncertainties.

3. To determine responsibility for the patient, refer to rule **420-2-1-.20 Responsibility For Patient**.

## Patient Rights and Refusal of Care
## 18.07

1. An adult is considered to be of sound mind unless he or she is obviously under the influence of drugs or alcohol or has been determined by a judge to be incompetent. If the person is obviously under the influence of alcohol or drugs, or threatens to harm him or herself, yet refuses treatment, contact OLMD and law enforcement if necessary. If the law enforcement officers are unable or unwilling to restrain the patient, the EMSP's responsibility is completed with his/her notification of the law enforcement agency and OLMD.

2. If a conscious, rational patient refuses treatment, comply with the patient's request and document the refusal. If, in the EMSP's judgment a patient who has refused treatment needs emergency care, contact OLMD.

3. If a patient's family, physician, or nursing home refuses treatment for a patient, contact OLMD.

4. An EMS Provider Service licensed in Alabama to transport patients may alter the destination choice of a patient from the patient's original destination hospital choice to the closest appropriate medical facility. Please continue to follow guidance from the Alabama Trauma Communications Center (ATCC) for all acute health systems patients.

5. If the patient is unconscious, has altered mental status, or who is unconscious and has unstable vital signs, the EMSP should attempt to take the patient to the most appropriate facility. If unsure, contact OLMD for guidance. Patients in cardiac arrest should always be transported to the closest emergency department.

6. If the transport of the patient would leave the community without ambulance service, the EMSP may request a backup ambulance from another area. This may require taking the patient (if unstable) to the nearest appropriate hospital while transportation is arranged. This is not intended to circumvent the Alabama Trauma System.

7. Minor Consent: **Code of Alabama 1975 §22-8-4:**

> Each of the following individuals may give effective consent to any legally authorized medical, dental, or mental health services for himself or herself and the consent of no other individual shall be necessary:
>
> (1) An individual who is 16 years of age or older.
> (2) A minor who has graduated from high school.
> (3) A minor who is married, or having been married, is divorced or has borne a child.

(4) A minor who is pregnant.
(5) A minor who is emancipated.
(6) A minor who is: (i) not dependent on a parent or legal guardian for support; **and** (ii) living apart from his or her parents or other individual(s) in loco parentis.

Nothing in this shall limit, preclude, or prevent the provision of any health care service to a minor when the health care provider providing the service has a good faith belief that one of the following conditions exist regarding the minor:

(1) An imminent threat
(2) Suspected abuse, neglect, or exploitation

Therefore, An EMSP may treat and/or transport, under the doctrine of implied consent, a minor who requires immediate care to save his/her life or prevent serious injury.

The age of majority in Alabama is 19 and therefore minors cannot sign legally binding documents, such a billing consents or refusals of care, until 19 years of age and parents still have the right to access medical records until a child reaches the age of majority.

If a situation arises where a patient of legal consent age refuses care and/or a parent or guardian refuses care which an EMSP thinks is medically necessary or any questions arise regarding minor consent, contact OLMD for further guidance.

8. In situations involving minors where contact cannot be made with a parent, legal guardian, or individual acting in loco parentis with no imminent threat to the patient requiring immediate treatment and transport under implied consent, OLMD should be contacted for further guidance.

9. In situations when a patient is in the custody of law enforcement personnel, the patient is the responsibility of the law enforcement personnel. In these circumstances, the EMSP is expected to confer with law enforcement personnel and make a recommendation regarding the most appropriate care for the patient. However, all decisions regarding these patients rest with law enforcement personnel, including destination hospital and consent or refusal of medical care. The law enforcement personnel are responsible for signing authorization for any refusal of care. If the situation arises in which the EMSP and law enforcement personnel disagree over the most appropriate care for the patient, OLMD should be contacted for consultation to ensure that law enforcement personnel have the most appropriate medical information available to allow them to make an informed decision regarding the patient's care.

## Time at the Scene
## 18.08

1. If at any time an EMSP cannot provide or protect a patient airway within five minutes after patient encounter and initiating emergency medical care, he or she is required to transport the patient immediately.

2. For cases involving significant trauma, time spent on the scene should be ten (10) minutes or less after extrication.

## Cancellation/Slow Down
## 18.09

The first licensed provider service unit on the scene may recommend that other responding units slow down or discontinue their response. It is recognized that it is in the best interest of patient care and the public to slow or cancel units responding with lights and siren to calls, when it is determined that the situation does not require such a rapid response.

# Crime Scene Response
# 18.10

The safety of EMSP and emergency care for the victim remain the primary goals in all crime scene operations; however, preservation of the scene remains the most important secondary goal. Never compromise patient care to preserve a crime scene. If the EMSP is part of an organized Tactical EMS arrangement with law enforcement units, such as SWAT teams, the EMSP will follow those operational guidelines, as approved by his/her Medical Director.

1. EMSP should not approach any scene suspected of involving violence, unless law enforcement states that the scene is reasonably secure. EMSP should not approach any crime scene in which law enforcement personnel are not present, in which law enforcement personnel are in defensive positions, or when weapons are being presented by law enforcement personnel.
2. EMSP should approach every call with caution while being observant. This is particularly true of scenes that may involve a crime against person or property. Noise and light discipline should be used with emergency warning equipment shut down some distance from the incident.
    a. A portable radio to call for assistance is recommended.
    b. Never stand directly in front of doors when knocking for entry.
    c. If a weapon is involved, try to secure the weapon unless the weapon is still in the assailant's possession. The weapon should be secured in such a way that it does not jeopardize the patient's life or the EMSP's life. Weapons are potential evidence and should not be compromised if possible.
    d. If the EMSP's life is in danger, it may be necessary to leave the patient. Always have a plan for escape.
3. All information regarding a call should be gathered. Calls involving crimes in progress, the use of weapons, or any suspicious call in high crime areas, should be treated with caution. If possible, EMSP should wear soft body armor on calls of this nature and while operating in high crime areas.
4. When approaching a crime scene with law enforcement present, ask for the best route of approach and avoid destroying what may be valuable evidence. Use only one route in and out of scene and disturb only what is absolutely necessary.
    a. Avoid disturbing tire tracks or footprints and avoid blood on surfaces.
    b. Do not disturb items on the scene unless absolutely necessary.
    c. Do not cut or treat through holes made by projectiles or other objects in clothing.
    d. Remove any medical items brought into the scene.
    e. When possible, place any victim to be transported on a clean sheet. When the victim is removed at the hospital, retain the sheet for law enforcement personnel. This is particularly important in crimes in which trace evidence may be transferred from the suspect to the victim. Retain, preferably wrapped in a clean sheet or placed in an unused paper bag, any clothing or other items

removed by EMS personnel while in the ambulance. Do not place blood-contaminated items in a plastic bag as this may ruin their value as evidence.

5. Do not touch or handle items, particularly weapons, found at a crime scene unless absolutely necessary. Do not handle expended bullets or casings with metal forceps if they should be found in clothing or on a sheet; retain them in the sheet or clothing in which they are found and notify law enforcement personnel. It is required that EMSP enter a crime scene to confirm obvious death, however, this procedure can be accomplished with minimal scene disturbance. Coordinate with law enforcement personnel in preserving the crime scene to the greatest extent possible.
6. Be aware of any statements made by victims, suspects or others present at a crime scene. Make certain to scan the scene, noting how it appears upon arrival, particularly the victim, and remember any changes made to the crime scene during patient assessment and/or treatment.
7. Following the incident, record detailed notes regarding actions and observations made during the incident. Any statements made outside the presence of law enforcement personnel, by the victim or suspect, should be carefully recorded, and a copy given to law enforcement investigators.
8. If a scene appears suspicious, then await the arrival of law enforcement personnel before approaching.
9. A detailed report that covers all aspects of the EMSP's involvement at the crime scene is important in case he or she is later called to testify in court. These narratives should cover the EMSP's observations and conversations with persons present at the scene, location of response vehicles and equipment, who was present, furniture, weapons, or clothing that has been moved, items that were handled by EMSP, and his/her route to the victim. This narrative should be a separate report from the Patient Care Report.

# Hazardous Materials
# 18.11

1. EMSP may be first on the scene of a hazardous materials situation. This guideline is intended to assist EMSP who do not normally function in hazardous material scenes and are trained only to the awareness level. This guide is intended to compliment any existing hazardous materials guidelines of fire agencies. The hazardous materials team protocol takes precedence.
2. Based on information from dispatch, if the scene to which an EMSP is responding is a known or suspected hazardous materials situation, stage and wait for the hazardous materials personnel.
3. When scene size-up suggests that hazardous materials are involved, stage and wait for the hazardous materials personnel.
4. All scenes should be considered as being a potential hazardous materials situation.

**Patient Care for the Contaminated Patient**

1. Types of incidents which may require decontamination of the patient:
    a. Radiation.
    b. Biological hazards.
    c. Chemical.
    d. Toxic Substances.
2. Contamination can occur through:
    a. Smoke.
    b. Direct contact.
    c. Vapor.
    d. Run-off.
3. Transporting contaminated patients should be a serious concern to those involved. Patients who have been in contact with, or who are even suspected of having been in contact with, a hazardous substance should be transported for evaluation.
4. The hazardous materials team must be contacted about removal of contaminated clothing and packaging of the patient with regard to the EMSP and the patient's protection.
5. Determine the hazardous substance involved, and provide treatment as directed by the EMSP in charge.
6. Be aware that many hazardous materials incident scenes are also crime scenes. Follow *Guideline 18.10 Crime Scene Response* when appropriate.

**Ambulance Preparation**

1. The EMSP shall determine the process needed for ambulance preparation.
2. Remove any supplies and equipment that would not be needed for immediate patient care.
3. Seal cabinets and drape interior, including floor and squad bench, with plastic or visqueen (if available from hazardous materials team).

4. Prepare stretcher by removing foam pad and placing down long backboard. Cover with plastic and tape in place, if needed (if available from hazardous materials team).

**Transport and Arrival at the Hospital**

1. If an ambulance has transported a patient from an incident that is subsequently determined to involve hazardous materials exposure, scene personnel must immediately relay all relevant information to the transporting unit(s) and/or receiving facility(s) involved.
2. OLMD and the receiving hospital should be contacted as soon as possible. The EMSP should communicate the material involved, degree of exposure, decontamination procedures used, and patient condition.
3. The ambulance should park in an area away from the emergency department, or go directly to a decontamination center or area.
4. Patient(s) should not be brought into the emergency department before the EMSP receive permission from the hospital staff.
5. Once the patient(s) has been released to the hospital, follow the EMSP direction and, if necessary, double bag the plastic sheeting used to cover the gurney and the floor into plastic bags. Double bag any equipment that is contaminated.
6. After unloading patient from ambulance, check with the fire department incident commander to see where the ambulance can be safely decontaminated, and whether or not there is equipment available for this purpose. Do not begin decontamination until after consultation with the Hazardous Materials Team Leader.
7. Following decontamination recommendation from the hazardous materials team, decontaminate the ambulance and personnel before returning to the incident scene. If returning to the incident scene, bring bags containing contaminated materials, equipment, clothing, etc., and turn them over to the hazardous materials team.

**EMSP Exposure**

1. If an EMSP is exposed, or is concerned with the possibility of exposure, medical help should be sought immediately.
2. Report all exposures to the hazardous materials team, Poison Center, and risk manager or supervisor.
3. Do not return to service until cleared to do so by the hazardous materials team.

## Air Ambulance Services
## 18.12

Air ambulance services should be utilized when transportation by air will significantly reduce total transport time for patients with time-dependent illness or injury, or when the patient requires potentially lifesaving prehospital interventions that cannot be provided by the responding EMS service.

**When an air ambulance service is requested, the service that can respond to the scene in the shortest time should be called**. If an air ambulance service cannot respond to a call and a second service is requested, the requesting agency must notify the second service that the call has already been refused and why. At no time should an air ambulance service be dispatched to a pre-hospital scene without dispatch of ground EMS, unless there are no other available EMS units. Air ambulance units may augment ground EMS services when the number of critically ill or injured patients requiring transport exceeds the transport capabilities of available ground EMS services.

Early activation of an air ambulance service is defined as dispatch of an air ambulance service to a patient care scene based on the information received though 911 operators or first responders on the scene.

Situations in which air ambulance services may be needed include, but are not limited to:
1. Patients who meet entry criteria for the Alabama Trauma System.
2. Multiple victim incidents with severe illness or injuries.
3. Severe burns and explosions.
4. New onset focal weakness, paralysis, or aphasia (suspected stroke).
5. ST Elevation MI or suspected acute coronary syndrome.
6. Near drowning.
7. Medical emergencies such as severe dyspnea, airway obstruction, or shock when, in the EMSP's best medical judgment, an air ambulance service would be the most appropriate form of transportation.
8. Report of serious injury in a patient whose location would be difficult to access by ground ambulance but is more accessible by helicopter.

When there is a question about whether or not an air ambulance service is the most appropriate means of transportation for the patient, contact OLMD for further guidance.

When an air ambulance service has been early activated or placed on stand-by status, it is the responsibility of the ground EMS service to determine if air transport is the most appropriate means of transportation for the patient and relay that information to the air ambulance service through their dispatch mechanism. If an air ambulance service has been activated and the highest level EMSP on the scene determines in his/her best professional judgment that air transport will not provide significant benefit to the patient, then the air

ambulance service should be cancelled as soon as possible. An air ambulance service request made by an ALS agency may only be cancelled by a licensed ALS Provider Service.

Upon arrival to the scene, if the air ambulance service crew determines that the patient does not meet criteria for air transport, or that patient, weather, or aircraft issues preclude use of the helicopter for transport, then the flight crew may request ground transportation for that patient. The flight crew may transfer care of the patient to the ground EMS crew in accordance with the *18.06 Medical Management of the Scene* operational guideline.

An EMS service should not delay transport of a patient while waiting for an air ambulance service to arrive. If an air ambulance service is delayed beyond their stated estimated time of arrival (e.g. >10 minutes), it is the responsibility of the service to notify the ground EMS crew of the delay. Hospitals may be used as a landing site and a patient will not be considered to have arrived at the hospital when the patient does not enter that facility for evaluation and/or care.

# Staging for High Risk Response
# 18.13

1. When to stage:
    a. Any time dispatch directs them to do so.
    b. Any time a violent incident might expose EMS personnel to danger.
    c. Any call at the EMS unit's discretion.
2. How to stage:
    a. Stage approximately two blocks from the incident address in urban areas and ½ mile from the incident address in rural areas and out of the line of sight.
    b. Announce arrival in staging and the location.
    c. Additional responding EMS units will respond to the same staging location if possible. (Avoid traveling past incident address).
    d. Unless traffic hazard, turn off headlights and all warning devices.
    e. Turn on four-way flashers.
    f. Once staged, EMS units will not enter the scene until the scene is declared secure by law enforcement or dispatch.

**NOTE**

It shall not be assumed that the mere presence of law enforcement on scene means that medical responders may now proceed safely into the call location. If law enforcement is on scene, call dispatch to request verification that EMS units may proceed onto the scene or stage. This may be modified depending on local situations.

# Infectious Diseases
# 19.01

EMSP may be first on the scene of a potential infectious disease situation. This guideline is intended to assist EMSP with identifying signs, symptoms, and appropriate management. Based on information from dispatch, EMSP should have a suspicion of any infectious disease potential. EMSP should don the appropriate PPE prior to entering the scene. If EMSP encounters individuals with symptoms of infectious diseases prior to donning PPE, stay more than six (6) feet away from individuals with symptoms and exercise appropriate PPE precautions. Once a specific Serious Infectious Disease (SID) has been confirmed, or has been suspected, the EMSP should contact the TCC for further instructions related to the disease. ADPH plans for specific SID's should be followed upon confirmation or orders from a Medical Control Physician.

**Signs and Symptoms of Most Infectious Diseases**

1. Rapid onset of symptoms
2. Difficulty breathing with exertion
3. Cough
4. Fever
5. Pleuritic chest pain
6. Nasal congestion
7. Muscle aches
8. Shaking chills
9. Sore throat
10. Headache
11. Diarrhea
12. Fatigue
13. Recent travel to infected regions

Those who exhibit fever, severe headaches, muscle pain, weakness, fatigue, diarrhea, vomiting, abdominal pain, and unexplained hemorrhaging (or bruising), and have recently travelled to the Congo, or the West Central region of Africa, may have contracted the Ebola virus. For those who are suspected of having Ebola, prior to transporting the patient, contact the ATCC for further instructions.

**Ambulance Preparation**

1. Any nonessential equipment that can be removed from the compartment of the ambulance before transport will hasten the time needed to disinfect and return to service.

2. Ensure good patient compartment vehicle airflow/ventilation (turn on exhaust fan) to reduce the concentration of aerosol accumulation when possible.
3. If necessary seal cabinets and drape interior, including floor and squad bench, with plastic or visqueen.
4. All patients with acute febrile respiratory illness should wear a surgical mask, if tolerated by the patient.

**Transport and Arrival at the Hospital**

1. When transporting a patient with symptoms of acute febrile respiratory illness, notify the receiving healthcare facility so that appropriate infection control precautions may be taken prior to patient arrival.
2. All EMSP engaged in aerosol generating activities (e.g. endotracheal intubation, bag-mask ventilation, nebulizer treatment, or CPAP [use expiratory filter]) should wear the appropriate PPE
3. The receiving hospital should be contacted as soon as possible. The EMSP should communicate patient condition and potential infectious disease.
4. EMSP should follow hospital procedures upon arrival in regards to patient routing.
5. Routine cleaning methods should be used throughout the transport vehicle and on non-disposable equipment. Routine cleaning with soap or detergent and water to remove soil and organic matter, followed by the proper use of disinfectants, are the basic components of effective environmental management of infectious diseases. Reducing the number of particles on a surface through these steps can reduce the chance of hand transfer of any particles.

Any disposable equipment should be placed in a biohazard bag and disposed of following a biohazard plan for infectious diseases.

# Community Paramedicine
# 24.01

The goals of a Community Paramedicine program are twofold: To improve overall health outcomes among medically vulnerable patient populations, and to prevent unnecessary ambulance transports, emergency department visits, and hospital readmissions.

The patient's primary care provider would refer the patient to a Community Paramedicine Program to provide services in the home that are within their scope of practice. This would include patients that are not eligible for home health care or hospice.

When not responding to emergencies, Community Paramedics can help people manage chronic diseases such as diabetes, high blood pressure, congestive heart failure, and prevent disease and illness through immunizations and screenings. They can provide information and counseling about ways to care for themselves and their families.

In home visits by a Community Paramedic may consist of things such as:

- o Reinforcement or explanation of health care discharge instructions and/or treatment plans
- o Provide medication reconciliation
- o Reminders of follow-up appointments
- o Fall prevention assessment in the home
- o Wellness screenings
- o Follow up lab work
- o ECGs, O2 saturation, BP checks, Blood glucose checks
- o Medication delivery
- o Immunizations
- o Documentation of actual medication compliance
- o Assessment of home environment
- o Need for in-home support services/ community resources
- o Mitigate any exacerbations of chronic illnesses
- o Timely warning signs of worsening conditions
- o Activation of an emergency response if necessary

The Community Paramedic will have additional training in non-traditional Paramedic interventions and a special certification as a community paramedic. Community Paramedicine is an extension of the primary care provider to provide care to patients with limited access to care and is not designed to replace the specialized services in a physician office, hospice program, or home health care programs.