Community Healthcare Integrated Paramedicine Program

CHIPP
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This manual may be used for the purposes of guiding Community Integrated Paramedicine program development in its original or edited format as long as reference is given to the author, Rio Rico Medical & Fire District.

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Rio Rico Medical and Fire District
Rio Rico, Arizona

Community Healthcare Integrated Paramedicine Program (CHIPP)
Policy Manual

POLICY: Purpose, Goals, and Objectives of the Community Healthcare Integrated Paramedicine Program (CHIPP)

POLICY NUMBER: CHIPP 1.1

APPROVED BY:

Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: This policy states that the Rio Rico Medical and Fire District will operate a community healthcare integrated paramedicine program, and defines the purpose of the Community Healthcare Integrated Paramedicine Program (CHIPP) of the Rio Rico Medical and Fire District. In addition, the program’s goals and objectives are outlined.

DEFINITIONS: “CHIPP” is an acronym standing for Community Healthcare Integrated Paramedicine Program (CHIPP had also meant Community Healthcare Integrated Paramedicine Project, particularly in its earlier phases and in related grant-funding and other documents related to the genesis of the program.

POLICY: Rio Rico Medical and Fire District (RRMFD) will operate a community healthcare integrated paramedicine program in order to improve the health of residents in the district by:

- Helping to connect community participants to available health resources in order to manage their health conditions more effectively.
- Effectively using RRMDF medical personnel to help close the gap between community participant needs and community health resources.
- Making home visits to participants identified as needing assistance, and assessing their health status and unmet healthcare needs.
- Encouraging and engaging participants to embrace self-care.
- Understanding and applying the principles of health promotion, positive health behavior change, motivational interviewing, wellness, and prevention approaches to minimize relapses, 911 calls, and hospitalizations, and to improve the participant’s overall health.
• Helping the participant to proactively seek primary care services for disease management.
• Teaching participants about their health conditions, medications, and treatments as well as about good approaches to health maintenance.
• Partnering with community health providers (primary care, home health, health educators, health plans) to support resource coordination for high-risk community members.

The services provided to patients in the CHIPP are different from acute, emergency medical situations dealt with by EMTs and paramedics working in the emergency medical services (EMS) environment and responding to emergency calls for help. Those services will be provided separately under RRMFD’s EMS program. The CHIPP program operates separately from the EMS program, dealing with non-emergency health issues that are chronic in nature, require routine primary care services, and seek ways to empower the participant to take charge of his own health care though preventive and wellness behaviors, and through making effective use of health resources available in the community. The CHIPP will operate under the oversight of a medical director, and will ensure that care provided is consistent with medical direction and EMT and paramedic scope of practice as defined by the Arizona Department of Health Services.

An additional outcome that the CHIPP will provide is to reduce overall medical costs in the community by preventing health condition setbacks, 911 calls, and hospitalizations that could have been prevented by better and proactive healthcare, use of community health resources, and developing positive health behaviors.

The CHIPP will evolve over time as it adapts to newly-discovered and changing community health care needs, and as innovative and effective strategies are developed to address such needs. In this regard, the CHIPP will also participate with other groups and agencies in assessing the community’s health care needs.

The skills used by the community paramedicine team will involve assessment, screening, teaching, collaborating, planning, communicating, problem-solving, promoting healthy behaviors, finding resources for unmet health needs, and encouraging participants toward wellness and self-care.

The CHIPP concept does not replace traditional concepts of “home health care” as provided by home health assistants and home health nurses. Neither does it replace nor conflict with the role of the “promotora” as it is practiced in this border community. CHIPP supplements the efforts of traditional “primary care” provided in the clinic setting by physicians, nurse practitioners, and other health care professionals. The emphasis in the CHIPP is connecting community residents with chronic health care conditions with available health care resources, helping to coordinate care from various sources, teaching participants, and encouraging health promotion and preventive behaviors.

The CHIPP goals are:
1. Improve the community health via the CHIPP.
2. Reduce repetitive 911 calls and hospitalizations related to sub-optimal management of chronic health conditions.
3. Reduce community health care costs through better coordination of care and prevention/wellness strategies.
The CHIPP objectives are:

1. Staff CHIPP with EMTs and paramedics who are properly educated regarding community paramedicine, and who have developed the required skill set.
2. Show annual growth in enrollment of CHIPP patient participants.
3. Achieve positive participant satisfaction with CHIPP.
4. Document a reduction in repetitive 911 calls and associated hospitalizations among those with chronic health conditions who are enrolled as CHIPP participants.
5. Demonstrate a reduction in community health care costs associated with chronic conditions.
6. Identify opportunities for improvement in CHIPP, take appropriate actions to make such improvements, and document the effectiveness in such actions.
Rio Rico Medical and Fire District
Rio Rico, Arizona

Community Healthcare Integrated Paramedicine Program (CHIPP)
Policy Manual

POLICY: Approach to and Philosophy of the Community Healthcare Integrated Paramedicine Program (CHIPP)

POLICY NUMBER: CHIPP 1.2

APPROVED BY: Les Caid, Chief Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: This policy presents the approach to the Community Healthcare Integrated Paramedicine Program (CHIPP) of the Rio Rico Medical and Fire District (RRMFD), as well as the philosophical assumptions underlying the program.

POLICY: The Community Healthcare Integrated Paramedicine Program (CHIPP) of the RRMFD is based on the following:

1) In view of the complexity of the health care system, community residents with continuing health problems will benefit from learning more about those problems. This increased knowledge, along with positive encouragement and support will lead to increased self-efficacy. As a result CHIPP participants will be less dependent, and motivated to take charge of their own health challenges.

2) When CHIPP participants learn about available community health resources, they will become more able to deal positively with health issues.

3) CHIPP participants will benefit from help in coordinating their medical care among their various health care providers.

4) CHIPP participants will be less likely to call 911 for a deteriorating medical condition, and less likely, therefore, to be readmitted to a hospital for a chronic medical problem.

5) CHIPP participants will be more likely to participate in preventive and wellness behaviors.
6) Persons who embrace prevention and wellness behaviors, and who gain knowledge and skills in positively dealing with their own medical conditions, will be able to manage their health more effectively and with less expense.

7) The RRMFD has personnel with the medical knowledge and skills to assist residents in positively dealing with their health challenges and medical conditions.

8) RRMFD personnel, being strategically based within the community, are uniquely positioned to be able to help with the coordination of medical care for individual residents among various health care providers, and are especially knowledgeable about the health resources available in the community.

9) With years of experience in providing emergency medical care to the community, often among the most challenging circumstances, RRMFD personnel are particularly able and available to provide non-emergency medical support for CHIPP participants.

10) The challenges of a rural and border environment, with its lack of extensive medical resources, can lead to some residents being medically underserved. RRMFD, offers the CHIPP to its community residents to help deal with these challenges.
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POLICY: Scope of Practice for Paramedics and EMTs Involved with the Community Integrated Paramedicine Program (CHIPP)

POLICY NUMBER: CHIPP 2.1

APPROVED BY: Les Caid, Chief

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Define scope-of-practice for Paramedics and EMTs working in the Community Healthcare Integrated Paramedicine Program (CHIPP) of the Rio Rico Medical and Fire District (RRMFD).

POLICY: The scope of practice for EMTs and for paramedics working in the CHIPP is exactly the same as for EMTs and paramedics working in EMS. That is, the scope of practice is as defined by the Arizona Department of Health Services Bureau of EMS and Trauma (for details, see Arizona Department of EMS rule R9-25-502. Scope of Practice for EMCTs, beginning on page 24 and including the following Tables 5.1 and 5.2 of the document located at http://apps.azsos.gov/public_services/Title_09/9-25.pdf).

What is different for CHIPP staff is that their practice is taking place in a different environment, that is, the CHIPP participants are not experiencing an emergency acute medical event (as in EMS), but are living with a chronic or ongoing medical condition. Also, EMS patients may experience their acute medical event anywhere, whereas the typical location for CHIPP participants will be in the home. The time environment is also different, with the EMS patient contact occurring unpredictably, and the CHIPP participant contact occurring on a scheduled, routine basis.

So, the role and practice environment is different, but the scope of practice is not.
Rio Rico Medical and Fire District
Rio Rico, Arizona

Community Healthcare Integrated Paramedicine Program (CHIPP)
Policy Manual

POLICY: Job Descriptions for the Community Healthcare Integrated Paramedicine Program (CHIPP)

POLICY NUMBER: CHIPP 2.2

APPROVED BY:

Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: This policy presents the staffing plan and the specific job descriptions for personnel working in the Community Healthcare Integrated Paramedicine Program (CHIPP) of the Rio Rico Medical and Fire District (RRMFD).

POLICY: The CHIPP staffing plan and job descriptions for each position are presented below.

Staffing Plan: The Community Healthcare Integrated Paramedicine Program (CHIPP) of the RRMFD is staffed by a mix of experienced Firefighter (FF) Paramedics (Certified Emergency Paramedic, CEP) and Firefighter (FF) Emergency Medical Technicians (EMT) with a core team who function in CHIPP capacity off shift (overtime/reserve status). A two-person team consisting of one CEP and one EMT will comprise the typical staffing for routine, scheduled CHIPP home visits. Two such 2-person teams will be available during the early phases of the CHIPP, supplemented by additional trained Community CEP’s and EMT’s as needed. Additional teams or approaches to staffing will be developed as the program grows.

The CHIPP Paramedic and CHIPP EMT will have completed the community paramedicine training curriculum before being assigned to this special duty. Individuals selected for CHIPP work will be well-experienced paramedics and EMT’s who have demonstrated qualities required for this specific role, as outlined in the individual job descriptions below; language considerations of the CHIPP team will be taken into account given population served. Service as a CHIPP paramedic or EMT will be in addition to routine assignment as a Firefighter/EMT or Firefighter/CEP.

In addition, the CHIPP Director will oversee the entire program, including: a) supervision of CHIPP EMT’s and Paramedics in their CHIPP-specific roles, b)administration of CHIPP-related grants, and c)
development of the CHIPP Consortium liaison with other Santa Cruz County fire departments as they become involved in CHIPP.

CHIPP Job Descriptions:

1) Job Description:
Community Healthcare Integrated Paramedicine Program (CHIPP)
Lead Community Integrated Paramedic
FTE: .5 (20 hours weekly)

General CHIPP Team Description

Each CHIPP team will be comprised of a Certified Emergency Paramedic (CEP) and an Emergency Medical Technician (EMT) who have completed the 21 hour community paramedicine training curriculum. Fire-Based Community Integrated Paramedicine Teams, while working in conjunction with local healthcare providers, will be a force multiplier in overall patient care while improving healthcare outcomes. Each CHIPP Team will be the eyes, and ears of community Primary Care Providers (PCP) & hospitals while in the home.

In conducting home visits, the RRFD has found that the initial visit will take approximately 90-100 minutes to complete not including follow-up paperwork. This initial visit includes obtaining vitals, patient baseline survey, medications review, and home environmental safety survey. Follow-up visits include participant assessment, vitals, and medications reconciliation. Follow-up visits last anywhere from 20 minutes to 1 hour depending on the need of the participant. We have found that they average 35 minutes. With these estimates in mind, we have created FTE estimates for community paramedic duties through this grant. FTE for community paramedic duties will vary based on the fire district and number of participants enrolled.

Lead Community Integrated Paramedic Duties

The Lead Community Integrated Paramedic (CIP) will support overall CHIPP activities through close collaboration with District leadership. The Lead CIP will interact with CHIPP teams to ensure consistency in services delivered to program Participants across sites. The Lead CIP will work out of the CIP office at RRMFD Station 3.

RESPONSIBILITIES INCLUDE:

- Support day to day operations of the CHIPP program in partnership with District leadership.
- Support the modification and creation of CHIPP operational procedures as updates/new policies are indicated
- Act as a main point of contact for community partners and Participants to address CHIPP care/operational issues
- Review program voicemails and emails daily with a keen focus on timely response
- Support resource linkage by communicating by phone, email and in-person with community resource representatives
- Review and educate team members regarding documentation completion and quality
- Support program performance improvement through documenting the review of Participant charts; follow up with CHIPP team members and other partners to ensure issue resolution
through direct and electronic communication and by providing additional training/resources as appropriate

- Provide support to academic and community guests interested in CHIPP activities; present to local, regional and national groups about CHIPP
- Support ongoing program needs through close collaboration and communication with the Program Director
- Attend CHIPP meetings as requested

ESSENTIAL FUNCTIONS:

- Leads the community paramedicine team during participant home visits.
- Provides community paramedicine care to the participant, including, but not limited to:
  - Careful and thorough assessment of new CHIPP participants with a focus on current illness/injury conditions, other chronic conditions that may be present, overall state of health, the participant’s knowledge about his health status, identifications of gaps in the health care plan for the participant, participant attitudes about his health, mobility issues, financial/resource concerns about healthcare, and identifying opportunities to solve health issues.
  - On-going re-assessments of the participant’s health status and progress in subsequent visits.
  - Providing general health education and condition-specific education to the participant.
  - A focus on wellness education and activities, including disease prevention and avoidance of relapses.
  - Encouraging and assisting the participant in setting health improvement objectives.
  - Helping the participant with medication management (in partnership with a pharmacist from the Arizona Poison & Drug Information Center) which includes general education about the purpose and proper use of the participant’s medications, answering medication-related questions, connecting the participant with additional resources regarding medications, using available resources to help solve medication issues, communicating problems to those who are prescribed medications when needed, and monitoring the participant for compliance with the prescribed medication regimen.
  - Helping the participant to understand hospital discharge plans and monitoring his progress under the plan.
  - Referral of the participant to healthcare resources when indicated.
  - Conducting home environmental surveys to prevent falls and other injuries, and providing environmental hazard removal/modification as resources allow.
  - Use of motivational interviewing techniques and other proactive health promotion approaches aimed at positive health behavior change.
  - Proper documentation of assessments and actions taken in the provision of care.
  - Function at the advanced level as expected of a paramedic.
- CHIPP personnel may not administer any medication that is not within the state scope of practice for paramedics, they may only administer medications that are within that scope of practice and outlined for use during a CHIPP by the Base Hospital Medical Director or designee.
- Completes initial CHIPP educational program, participates in CHIPP continuing education and program improvement activities.
- Demonstrates continuous effort to improve CHIPP operations and work processes. Works cooperatively with fellow CHIPP team members.
• Provides quality customer service and achieves customer satisfaction as demonstrated by participant feedback.
• Performs other duties as assigned.

REQUIRED KNOWLEDGE and SKILLS:

• Successful completion of the CHIPP introductory education.
• Participates in CHIPP-specific continuing education programs.
• Understands Community Healthcare Paramedicine techniques with a focus on in-home and chronic condition assessment, prevention, wellness, motivational interviewing, use of community health resources, ability to assist participant to set reasonable healthcare goals, ability to promote and encourage client self-care and independence, excellent communication skills with other healthcare providers, and ability to make appropriate referrals to other medical care providers.
• Demonstrates thorough knowledge of CHIPP algorithms provided by the Base Hospital Medical Director, and shows ability to competently apply such decision algorithms in the community paramedicine setting.
• Complies with all applicable Arizona DHS rules, regulations, directives, and guidelines regarding community paramedicine.
• Maintains Arizona Paramedic certification, and is in good standing with employer and Base Hospital Medical Direction expectations.
• Practices internal and external customer service according to the RRMFD WAY.

2) Community Paramedic

ESSENTIAL FUNCTIONS:

• Leads the two-person community paramedicine team during participant home visits.
• Provides community paramedicine care to the participant, including, but not limited to:
  o Careful and thorough assessment of new CHIPP participants with a focus on current illness/injury conditions, other chronic conditions that may be present, overall state of health, the participant’s knowledge about his health status, identifications of gaps in the health care plan for the participant, participant attitudes about his health, mobility issues, financial/resource concerns about healthcare, and identifying opportunities to solve health issues.
  o On-going re-assessments of the participant’s health status and progress in subsequent visits.
  o Providing general health education and condition-specific education to the participant.
  o A focus on wellness education and activities, including disease prevention and avoidance of relapses.
  o Encouraging and assisting the participant in setting health improvement objectives.
  o Helping the participant with medication management (in partnership with a pharmacist from the Arizona Poison & Drug Information Center) which includes general education about the purpose and proper use of the participant’s medications, answering medication-related questions, connecting the participant with additional resources regarding medications, using available resources to help solve medication issues, communicating problems to those who are prescribed medications when needed, and monitoring the participant for compliance with the prescribed medication regimen.
Helping the participant to understand hospital discharge plans and monitoring his progress under the plan.
- Referral of the participant to healthcare resources when indicated.
- Conducting home environmental surveys to prevent falls and other injuries, and providing environmental hazard removal/modification as resources allow.
- Use of motivational interviewing techniques and other proactive health promotion approaches aimed at positive health behavior change.
- Proper documentation of assessments and actions taken in the provision of care.
- Function at the advanced level as expected of a paramedic.

- CHIPP personnel may not administer any medication that is not within the state scope of practice for paramedics, they may only administer medications that are within that scope of practice and outlined for use during a CHIPP by the Base Hospital Medical Director or designee.
- Completes initial CHIPP educational program, participates in CHIPP continuing education and program improvement activities.
- Demonstrates continuous effort to improve CHIPP operations and work processes. Works cooperatively with fellow CHIPP team members.
- Provides quality customer service and achieves customer satisfaction as demonstrated by participant feedback.
- Performs other duties as assigned.

REQUIRED KNOWLEDGE and SKILLS:

- Successful completion of the CHIPP introductory education.
- Participates in CHIPP-specific continuing education programs.
- Understands Community Healthcare Paramedicine techniques with a focus on in-home and chronic condition assessment, prevention, wellness, motivational interviewing, use of community health resources, ability to assist participant to set reasonable healthcare goals, ability to promote and encourage client self-care and independence, excellent communication skills with other healthcare providers, and ability to make appropriate referrals to other medical care providers.
- Demonstrates thorough knowledge of CHIPP algorithms provided by the Base Hospital Medical Director, and shows ability to competently apply such decision algorithms in the community paramedicine setting.
- Complies with all applicable Arizona DHS rules, regulations, directives, and guidelines regarding community paramedicine.
- Maintains Arizona Paramedic certification, and is in good standing with employer and Base Hospital Medical Direction expectations.
- Practices internal and external customer service according to the RRMFD WAY.

3) **Community Emergency Medical Technician**

ESSENTIAL FUNCTIONS:

- Works under the paramedic’s supervision as a member of the two-person community paramedicine team (at the EMT-Basic level) during participant home visits.
Provides community paramedicine care to the participant (at the EMT-Basic level), including, but not limited to:

- Basic assessment of new CHIPP participants with a focus on current illness/injury conditions, other chronic conditions that may be present, overall state of health, the participant’s knowledge about his health status, identifications of gaps in the health care plan for the participant, participant attitudes about his health, mobility issues, financial/resource concerns about healthcare, and identifying opportunities to solve health issues.
- On-going re-assessments of the participant’s health status and progress in subsequent visits.
- Providing general health education and condition-specific education to the participant.
- Possess the ability to focus on wellness education and activities, including disease prevention and avoidance of relapses.
- Encouraging and assisting the participant in setting health improvement objectives.
- Helping the participant with basic medication management issues which include general education about the purpose and proper use of the participant’s various medications, answering basic medication-related questions, connecting the participant with additional resources regarding medications, using available resources to help solve medication issues, communicating problems to those who are prescribe medications when needed, and monitoring the participant for compliance with the prescribed medication regimen.
- Helping the participant to understand hospital discharge plans and monitoring his progress under the plan.
- Referral of the participant to healthcare resources when indicated.
- Conducting home environmental surveys to prevent falls and other injuries, and providing environmental hazard removal/modification as resources allow.
- Use of motivational interviewing techniques and other proactive health promotion approaches aimed at positive health behavior change.
- Proper documentation of assessments and actions taken in the provision of care.
- Functions, under the leadership and supervision of the Paramedic, at a basic level as expected of an EMT-Basic.

- CHIPP personnel may not administer any medication that is not within the state scope of practice for EMCTs, they may only administer medications that are within that scope of practice and outlined for use during a CHIPP by the Base Hospital Medical Director or designee.
- Completes initial CHIPP educational program, participates in CHIPP continuing education and program improvement activities.
- Demonstrates continuous effort to improve CHIPP operations and work processes. Works cooperatively with fellow CHIPP team members.
- Provides quality customer service and achieves customer satisfaction as demonstrated by participant feedback.
- Performs other duties as assigned.

REQUIRED KNOWLEDGE and SKILLS:

- Successful completion of the CHIPP introductory education.
- Participates in CHIPP-specific continuing education programs.
• Community Healthcare Paramedicine techniques (at the EMT-Basic level) with a focus on basic in-home and chronic condition assessment, prevention, wellness, motivational interviewing, use of community health resources, ability to assist participant set reasonable healthcare goals, ability to promote and encourage client self-care and independence, excellent communication skills with other healthcare providers, and ability to make appropriate referrals to other medical care providers.
• Demonstrates thorough knowledge of CHIPP algorithms provided by the Base Hospital Medical Director, and shows ability to competently apply such decision algorithms in the community paramedicine setting.
• Complies with all applicable Arizona DHS rules, regulations, directives, and guidelines regarding community paramedicine.
• Maintains Arizona EMT Basic certification, and is in good standing with Base Hospital Medical Direction expectations.
• Internal and external customer service according to the RRMFD WAY.

4) CHIPP Project Director (reports to Chief of RRMFD)

ESSENTIAL FUNCTIONS:

• Plan the Community Integrated Healthcare Paramedicine Program (CHIPP).
• Develop, implement, and direct the program, initially in phases over a three-year rollout, then continuing further development as indicated.
• Ensure that routine CHIPP operations are carried out effectively.
• Ensure scheduled participant appointments are being met.
• Deliver and collect satisfaction surveys from participants. Ensure participant satisfaction.
• Direct, supervise, and evaluate personnel in their CHIPP-specific roles.
• Develop a database for the CHIPP, and manage the data collection and input processes.
• Assess the reliability, validity, and appropriateness of data collection methods, survey designs, and quality controls.
• Effectively retrieve usable data for analysis. Analyze the data using appropriate methods, and with an emphasis on continuous and sustainable use of evaluation to inform decision-making.
• Using the database and other appropriate inputs, evaluate the CHIPP on the formative, process, and outcome levels.
• Using analysis of the data as a foundation, make adjustments and changes to the program to improve quality, while focusing on effectiveness and efficiency.
• Communicate quality improvement information to staff, the CHIPP Consortium, and community stakeholders.
• Effectively administer CHIPP-related grant requirements. Obtain grant funding when available.
• Provide program liaison with community partners.
• Demonstrate leadership with the CHIPP team, consortium, and community partners.
• At the direction of the Chief, participate in community paramedicine development activities on a state-wide basis, including attendance at appropriate meetings.
- Report on the CHIPP to the Chief of RRMFD.

REQUIRED KNOWLEDGE and SKILLS:

- Bachelor’s degree in public health or a related field.
- Minimum of three years’ experience in project management, or at least five years of employment as a fire officer and paramedic.
- Complete initial community paramedic training program.
- Knowledge of the principles of community paramedicine, and relevant Arizona DHS rules, regulations, and guidelines.
- Appropriate experience in public administration, business, public health, or related field.
- Appropriate experience in evaluation work (including overseeing data collection, data analysis, and compiling and presenting data), and program assessment (outcome/impact analysis).
- Appropriate experience in education and teaching.
- Proficiency with Microsoft Office including Outlook, Word, Excel, and PowerPoint.
POLICY: Roles in Home Health Care

POLICY NUMBER: CHIPP 2.3

APPROVED BY: Les Caid, Chief

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Compare and contrast the roles of various types of home health care providers.

POLICY: This policy presents the various roles of persons involved in providing home-based health care in the Rio Rico community. The purpose is to illustrate the concepts involved with the Community Healthcare Integrated Paramedicine Program (CHIPP) of the Rio Rico Medical and Fire District (RRMFD), and compare its program with other services that may be available to community participants. Anticipating that there will be distinctions among the various community health provider roles, as well as some overlaps, information presented here will be helpful in coordinating care among various community health care provider roles.

RRMFD CHIPP – In-home visits by community paramedicine (EMTs and paramedics), health assessment, emphasis on gaining skills for self-care, coordinating various health care providers, prevention and wellness. See CHIPP Policies # 1.1 and 1.2. The scope of practice of the EMT and paramedics are the same as for all such Arizona personnel practicing in the EMS environment, but the setting and roles are different, in that the participants served are typically at home and living with chronic health issues (as opposed to acute, emergency health situations in the EMS setting) – see CHIPP Policy 2.1

Home Health Agencies – In-home nursing care by nurses (RNs and LPNs), Certified Nursing Assistants, home health aides or assistants, and sometime specialized therapists such as physical therapists. Services provided by nurses and therapists may include medication administration, hands-on help with technical home medical devices, and direct therapy and treatments. CNAs and aides/assistants usually provide medically simple hands-on care, mobility, and help with activities of daily living. Current agencies providing this level of home care in Santa Cruz County include “Dependable Home Health,” “Consumer Direct,” and “Luminaria Home Health.”

Mental Health – Mental health experts at various competency levels, from assistants up to masters-prepared mental health therapists may, at times, assist individuals with mental health care in a home-based environment in Santa Cruz County. This includes Cenpatico (the regional behavioral health authority) and their subcontractors “Community Health Associates,” and “Pinal Hispanic Council.”
**Durable medical equipment providers** – Retail sales and home delivery of various types of home medical care equipment and supplies. A central supplier in Santa Cruz County is “Dependable Medical Equipment.”

**Oxygen.** – Provide oxygen tanks and refills, as well as home delivery of oxygen.

**Mariposa Community Health Center’s Las Promotoras de Salud** – Promotoras are bilingual individuals knowledgeable about Hispanic/Latino culture, trained to provide information, health education, and support to improve patient compliance and improve health outcomes for patients with chronic disease. Their education for this role is provided by MCHC and through on-the-job training. They provide one-on-one education in the home or in the clinic. They also conduct healthy lifestyle and physical fitness classes through Platicamos Salud. MCHS also provides their one-on-one Care PLUS diabetes education service. Promotoras also encourage patient self-care, assess the home environment, and educate patients about health and safety risks.

**Primary care providers doing house calls** – On occasion, some primary care providers may make house calls and provide in-home assessment, diagnosis, treatment, medication, and prescriptions.

**Volunteers providing home-based services or assistance** – Volunteers who may be able to assist in-home, particularly the elderly, at times simply by making phone calls to check on their status. An example in Santa Cruz County is “Telecare.” (See CHIPP Policy 8.6 and the current “community health resource list.”)
Community Healthcare Integrated Paramedicine Program (CHIPP)
Policy Manual

POLICY: Initial Education in “Community Paramedicine” for personnel working in the Community Integrated Paramedicine Program (CHIPP)

POLICY NUMBER: CHIPP 2.4

APPROVED BY:  
Les Caid, Chief  
Joshua Gaither, MD  
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Define the initial education required of all personnel working in Rio Rico Medical and Fire District’s Community Integrated Paramedicine Program (CHIPP).

POLICY: All personnel must successfully complete the following initial minimum 21-hour educational program in “Community Paramedicine” in order to be assigned to work in the CHIPP. The curriculum consists of the following:

2 hours Orientation to CHIPP: What community paramedicine is, and how it differs from EMS. Scope of practice.
0.5 hours Stop Smoking Programs available in the community
5 hours Motivational Interviewing
4 hours Diabetes
4 hours Chronic Respiratory Diseases: Asthma and COPD
4 hours Chronic Cardiac Diseases: Congestive Heart Failure, Post-Myocardial Infarction, Angina
4 hours Behavioral Health, including Dementia and Alzheimer’s Disease
3 hours Medications and Medication Management (including meds for diabetes, respiratory diseases, cardiac diseases, and dementia)

This educational program will be offered as needed.
POLICY: Continuing Education for Personnel working in the Community Integrated Paramedicine Program (CHIPP)

POLICY NUMBER: CHIPP 2.5

APPROVED BY: Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: This policy presents the expectations for personnel working in the Community Healthcare Integrated Paramedicine Program (CHIPP) regarding continuing education in the field of “community paramedicine”.

POLICY: All personnel working in the CHIPP will annually attend a minimum of 80% of the continuing education programs provided by Rio Rico Medical and Fire District listed as being for “community paramedicine” personnel.

Certain programs will be listed as “required” for all CHIPP personnel. These programs will be offered more than once, or in a format allowing for completion on an individual basis. All CHIPP personnel must attend 100% of the required programs.

Continuing education programs in community paramedicine will cover a variety of topics, similar to those listed below:

- Wellness and health promotion
- Motivating participants to embrace self-care
- No smoking programs
- Programs covering pathophysiology and clinical aspects of home care for chronic diseases often faced by those at home, such as...
  - Cardiac diseases
  - Respiratory diseases
  - Diabetes
Renal diseases
Musculoskeletal and auto-immune diseases
Cancer care in the home, including issues associated with chemotherapy and radiation therapy.
Mental and behavioral health, including conditions such as dementia, depression, and schizophrenia.

- Post-surgery care issues
- Mobility issues, including fall prevention
- Home safety and injury prevention; environmental assessment; safety problem-solving
- Dealing with participant medication issues
- Documenting in community paramedicine
- Quality improvement in community paramedicine
- Enrolling new participants
- Medical direction, decision algorithms, and scope of practice issues
- Creative problem-solving in community paramedicine
- Coordination of care, communicating with other care providers, and inter-acting with other healthcare providers and agencies
- Community healthcare resources fair
- Other related topics
Section 3: Enrollment and Discharge

3.1 Finding and Recruiting New CHIPP Patients
3.2 Enrolling New CHIPP Participants
3.3 Promoting the CHIPP in the Community
POLICY: Finding and Recruiting New CHIPP Participants (Community Integrated Paramedicine Program)

POLICY NUMBER: CHIPP 3.1

APPROVED BY: Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Develop and implement a plan for finding and recruiting new CHIPP participants.

POLICY: The CHIPP will develop, implement, and maintain a plan for finding and recruiting new CHIPP participants. Such plan will include:

1) A mechanism to coordinate with Holy Cross Hospital in Nogales regarding patients discharged from that facility to home, if the residence is within the Rio Rico Medical and Fire District.
2) This should include, as possible, referral from Holy Cross Hospital to RRMFD for follow-up assessment and possible enrollment into the CHIPP of the patient discharged from Holy Cross Hospital, when clinically indicated.
3) A plan to receive from Holy Cross Hospital a regular list of EMS patients transported to Holy Cross Hospital by Rio Rico Medical and Fire District.
4) Procedures for review of patients discharged from Holy Cross Hospital for possible enrollment in the CHIPP, when indicated.
5) Regular contact (via ongoing telephone and email communication as well as interaction at monthly CHIPP meetings and other meetings as indicated) between the CHIPP Lead Community Integrated Paramedic and a key contact person at Holy Cross Hospital (such as a person responsible for discharge planning, the ED Nurse Manager, or the Director of Nursing) to maintain open communications about the RRMFD CHIPP and potential referrals from Holy Cross to CHIPP.
6) A mechanism to coordinate with Mariposa Clinic regarding patients cared for at that facility, who may be candidates for participation in the CHIPP, if the patient residence is within the Rio Rico Medical and Fire District.
7) This should include, as possible, referral from Mariposa Clinic to RRMFD for follow-up assessment and possible enrollment into the CHIPP of Mariposa patients, when clinically indicated.
8) Regular contact between the CHIPP Lead Community Integrated Paramedic and a key contact person at Mariposa...
Clinic (such as a person responsible for discharge planning, the Promotora program, or a key manager or director) to maintain open communications about the RRMFD CHIPP and potential referrals from Holy Cross to CHIPP.

9) Where possible, similar mechanisms to coordinate care, receive referrals to CHIPP, and receive lists of potential CHIPP candidates from other regional medical facilities and programs.

10) Where possible, regular contact (ongoing communication via email and telephone as well as attendance at appropriate care coordination meetings) between the CHIPP Lead Community Integrated Paramedic and key contact persons at other regional medical facilities and programs (such as persons responsible for discharge planning, ED Nurse Managers, or Directors of Nursing) to maintain open communications about the RRMFD CHIPP and potential referrals from those regional medical facilities and programs to CHIPP.

11) A schedule of activities to provide the RRMFD community information about the CHIPP, including marketing and advertising.

12) A procedure for weekly (and ongoing as indicated) review of RRMFD EMS responses to identify potential CHIPP participants. This procedure should include a means to identify individuals who have called EMS multiple times.

13) A procedure for responding to potential CHIPP participants as a “treat and refer” case from a RRMFD EMS response where it is found that the patient does not require transport to a medical facility, but can safely remain at home with follow-up by CHIPP.¹

14) A procedure for responding to potential CHIPP participants as a “treat and refer” case from another EMS agency response where it is found that the patient does not require transport to a medical facility, but can safely remain at home (within the RRMFD service area) with follow-up by CHIPP.¹

15) Other outreach activities regarding CHIPP to the RRMFD community.

16) A simple method for community residents to contact RRMFD for possible participant enrollment in CHIPP, or to receive from a citizen referral information about another individual who might benefit from CHIPP enrollment.

17) Based on previous CHIPP activity, the CHIPP Director will set annual goals for the number of CHIPP participants.

18) The CHIPP Director will annually evaluate achievement of CHIPP enrollment goals.

19) The CHIPP Director will be responsible for ensuring that this program is carried out.

REFERENCES:

¹ Bureau of Emergency Medical System and Trauma System (BEMSTS). **ARIZONA TREAT AND REFER PROGRAM: A monitored, community specific, and clinically grounded effort to enhance the healthcare continuum for Arizonans.** Phoenix: Arizona Department of Health Services (ADHS), May 19, 2016. Document at
POLICY: Enrolling New CHIPP Participants (Community Integrated Paramedicine Program)

POLICY NUMBER: CHIPP 3.2

APPROVED BY: [Signature]

Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Develop and implement a plan for initial enrollment of new CHIPP participants.

POLICY: The CHIPP will develop, implement, and maintain a plan enrolling new CHIPP participants. The plan will include:

1) Various mechanisms by which an individual may be referred to RRMFD CHIPP, including self-referral or referral by another individual, referral by RRMFD EMS, referral by another EMS agency, referral from Holy Cross Hospital, referral from Maricopa Clinic, referral by another hospital, referral by a primary care provider, or referral by another health care provider.

2) An initial contact is made with the potential CHIPP participant by CHIPP personnel.

3) The individual agrees to enroll in the CHIPP program. CHIPP personnel schedule and in-person visit, and communicate to the assigned CHIPP provider about new participant, placing that participant and first visit on the CHIPP participant schedule.

4) At the first home visit with the participant, the participant signs the enrollment form (see page 7 below), and the program begins (see policy CHIPP #4.1).

See attached to this policy, the “Participant Enrollment Flow” (page 2 of this policy) and a narrative description of the referral process, steps of the enrollment process, including the initial screening process, and an initial contact telephone script (pages 3-6 of this policy). Also attached is a copy of the “CHIPP Participant Referral form” on page 5 of this policy, and on page 7 the participant consent form.
Rio Rico Medical & Fire District Community Integrated Paramedicine Program

**Participant Enrollment Flow**

- **Individual Referred to CIP** (Various Sources)
  - Individual Interested/Suitable for CIP Enrollment
  - Initial CIP Visit Scheduled

- **Initial CIP Visit Completed (Phase 1, Visit 1):**
  - CIP Overview
  - Consent
  - Intake Interview/Assessment
  - Referral & Follow-up Planning
  - Complete Documentation

- **Follow-up CIP Visits Completed (Phase 1, Visits 2-15*):**
  - Weekly (may vary depending on Participant need, condition)
  - Follow-up Interview/Assessment
  - Referral & Follow-up Planning
  - Complete Documentation
  - *Participant may graduate from Phase 1 early, see red section

- **Final CIP Visit Completed (Phase 2, Visit 16**):**
  - Final Visit Interview/Assessment
  - Referral & Follow-up Planning
  - Complete Documentation
  - Determine Graduation Status (may Graduate to Phase 3 or Re-enroll in Phase 1)
  - **may occur prior to visit 16 if early graduation criteria met

- **Individual Screened by CIP Program Staff** for interest and to determine suitability for enrollment. Screen individuals for current PCP status and enrollment in in-home health services (active visits with home health/CHW visitation, other in-home care services).

- **Individual Not Interested/Suitable** for CIP enrollment (concurrent enrollment in other care coordination services). Obtain verbal permission to contact current source of care/referral source to arrange follow up as appropriate.

- **Offer other appropriate referral options indicated by phone call:** PCP resources, community wellness programs, etc.

- **Early Graduation** from Phase 1 may occur after at least 30 days of enrollment and:
  - No 911 use for 30 days
  - No ED/IP admission for 30 days
  - Adherent to Rx for 30 days
  - Established PCP at time of graduation

  **OR AFTER**
  - appropriate resources deemed available, i.e. home health, case management, hospice, other in-home health services)

- **Follow-up Phone Calls** (Phase 3, Calls 1-4):
  - Standardized phone calls completed post-Phase 2 Graduation
  - May offer re-enrollment if indicated
I. Individual referred to CIP:

Referral sources:

Potential CIP Participants will come from a variety of sources. These sources may include:

- High Utilization of 911: ≥ 4 calls in last 6 months (Through District)
- Individuals admitted ≥ 2 times in past 6 months (Referral by Acute Care Facility)
- Individuals > 55 years with chronic disease (Community Referral, PCP)
- Target Individuals > 55 years with chronic disease in all categories

This is not an all-inclusive list of potential referral sources. District employees, community members, clinicians and other healthcare professionals may contact Rio Rico Medical & Fire District regarding interest in CIP services for screening.

District identification of individuals in the “High Utilization of 911” category will be monitored by the CIP program director who will note ongoing concerns raised by District staff regarding high frequency callers and by structured review of District 911 call data (in conjunction with District Administrative Manager and EMS Coordinator).

Medical providers may use the “CHIPP Participant Referral Form” to alert CIP staff when an individual shows interest in learning about the CIP program (overview for clinical providers). Upon completion of the “CHIPP Participant Referral Form” (including obtaining a signature from the interested individual consenting to being contacted by CIP program staff) the form will be faxed or emailed to the CIP program as indicated on the form. This form shall be kept by the District.

“CHIPP Participant Referral Form”
The referral form will support CIP staff to focus on identified health concerns. Highlighting why an individual may benefit from CIP services will allow program staff to tailor encounters, resources provided, and linkage to services already in place for Participant.
Individual screened by CIP program staff:

All efforts for CIP recruitment will be documented in the “CIP Referral Log” (as of 12.21.2015 on the RRFD share drive under Documents: CHP: CHP 5.1.2015 Forward: CHIPP Referrals). Pertinent information will be included such as name, contact information, communication attempts/notes, and outcome of recruitment (CIP visit scheduled, individual not interested, referral to health resource type, etc), date for future follow up.

Upon contacting any individual, CIP program staff will identify themselves by name, their role with the District, and reason for calling (referral from a medical provider, follow-up from previous 911 calls, etc).

RRMFD Script to guide Initial Contact Phone Call:

“Hello, my name is _____ . I am a _____ (FF/(CEP/EMT)) from the Rio Rico Medical and Fire District. I am calling because we ____________ (“responded to your home in the past” or “received a referral from your healthcare provider”).

How have you been feeling since _______ (“we responded to your home” or “you last saw your doctor?”).

Do you have any health concerns at the moment? If yes, what are they? ________________

Have you followed up with your health care provider ____________? (“since we transported you” or “since you started having this concern?”). Yes / No

Who is your usual source of primary care? List provider: ______________________________

We would like to update your provider about the care we provided to you. Is it okay with you that we contact [provider name] on your behalf? Yes / No

(If Mariposa PCP, we will contact Miriam Islava to coordinate in-home services as appropriate. If other community PCP we may continue with CIP enrollment if no other active in-home services provided).

If referral to MCHC: Ok, I will contact Mariposa to follow up about your care. You should hear from them within the next few days. We will give you a call in about one week to check in.

[Email to Miriam Islava mislava@mariposas chc.net with Individuals Name, DOB, Address and Phone. Use “Referral to MCHC Form” located in the RRFD Share Drive: CHP: CHP 5.1.2015 Forward: CHIPP Referrals).

If other community PCP or No PCP: With your permission I would like to schedule an appointment to discuss your health concerns and medications. During that time our team, which consists of an EMT and paramedic, will be able to:

- Check your blood sugar
- Check blood glucose if you are having issues with your blood sugar
- Perform a home safety scan for any fall or any other hazards
- Conduct a one-on-one health scan
• Make referrals to helpful health services
• Smoke / Carbon Monoxide detector installations
• Car seat
• Electric Burners
• Check fire extinguishers

What day works best for you? ______

Do you prefer mornings or afternoons? ______

Ok, I have you scheduled for ________.

Before I hang up, I want you to make sure that if a medical problem arises, for example, chest pain, or shortness of breath, you need to call 911 to see a doctor right away. If you are having a medical problem that is not an emergency, call your doctor’s office directly and ask for an earlier appointment.

Do you have any questions? Yes: Address questions or let individual know you will follow up. / No

If No, ...Okay, Mr./Mrs. ________ I appreciate you taking the time to talk with me. We look forward to serving you and the community. Thank you and have a great day!”

**Initial CIP visit completed (Phase 1, Visit 1):**

Each phase of participant visits will follow a standard format. Please see the most up to date compilation of visit information to be completed (many questions are dependent upon diagnosis of particular disease(s)): [https://drive.google.com/open?id=17lZoTOYK80sXMzPFEMB1_3CQ_cMhpL68b9YZLfsDtb8](https://drive.google.com/open?id=17lZoTOYK80sXMzPFEMB1_3CQ_cMhpL68b9YZLfsDtb8).

Each visit is organized into the following sections:

A. Visit Details
B. CHIPP Overview
C. Consent
D. Participant Information
E. Referral to CHIPP
F. Participant Assessment/Vitals/Guidelines
G. Medical Care
H. Medication Adherence
I. Fall/Environmental Assessment
J. Chronic Disease Management (General and Disease-specific)
K. Participant Plan/Notes
L. Resource Linkages

Please see Attachment I which includes all assessments and sources.
CHIPP Participant Referral Form
Rio Rico Medical & Fire District
Community Healthcare Integrated Paramedicine Program (CHIPP)

Phone: 520.761.0104
Fax: 520.281.7670
Address: 822 Pendleton Drive
Rio Rico, AZ 85648

Referral Criteria: An individual may be referred who exhibits risk for 911 use, hospital readmission, etc. Check all categories that apply.

- ≥ 4 911 calls in past 6 months
- Admitted as an inpatient ≥ 2 times in past 6 months
- Pending Inpatient Discharge
- Other:

Medical Condition(s):
- Diabetes
- Asthma
- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Hypertension (HTN)
- Recent Myocardial Infarction (MI)

Please complete this form, including patient signature, to authorize RRMFD CHIPP staff to contact the interested individual about potential program enrollment.

- If you are interested in the program and you are NOT being referred by a healthcare provider, please call us directly to discuss program details.

- CHIPP services are offered at no cost as a service of the RRMFD supported by a Health Resources and Services Administration (HRSA) Rural Health Outreach Grant.

**BASIC INFORMATION**

Date of referral:
Requested Date of Service:
Patient Primary Language:

Patient name
First:
Middle:
Last:
DOB:
Gender: M | F

Physical Street Address:
City/State:
Zip Code:
Phone:

**DIAGNOSIS INFORMATION:**

Diagnosis 1:
- Nutrition

Diagnosis 2:
- Social Evaluation/Social Support

Diagnosis 3:
- Home Safety Inspection (Fall hazards/General Safety)

Reason for visit:
- Environmental Evaluation (Respiratory)

**CLINICAL CARE (CHECK ALL THAT APPLY):**

**Respiratory**

- Blood Pressure Check
- Asthma Meds/Education/Compliance
- CPAP
- MDI Use
- Nebulizer Usage/Compliance

Follow-Up/Post Discharge
- Peak Flow Meter Education/Usage
- Oxygen Saturation Check
- Post MI assessment/Follow up

- Neurological Assessment
- Capnography Reading

Other:

**VISIT REQUEST DETAIL:**


**REFERRAL SOURCE:**

- PCP Referral
- Other Provider:

Contact Phone/Email:
Name:
Signature:

**PATIENT INFORMATION AND AUTHORIZATION:**

Authorizing the referral source to share your personal information with the Rio Rico Medical & Fire District, RRMFD will contact you regarding potential enrollment in the Community Healthcare Integrated Paramedicine Program.
# Santa Cruz County CHIPP Consortium

## Community Healthcare Integrated Paramedicine Program

Consent/Authorization to Participate and Share Medical Information

**BASIC INFORMATION**

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<th>Field</th>
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<td>Date of order</td>
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<td>Requested Date of Service</td>
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<td>Primary Language</td>
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<td>Patient name: First</td>
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<td>Middle Initial</td>
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<td>Gender</td>
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<td>Physical Street Address</td>
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<td>City/State</td>
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**DIAGNOSIS:**

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<th>Field</th>
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<tbody>
<tr>
<td>Diagnosis</td>
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<td>Reason for Release</td>
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**INFORMATION TO BE SHARED**

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<td>Consult</td>
<td>[ ]</td>
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<tr>
<td>History and Physical</td>
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<td>X-Ray Report</td>
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<td>Discharge Summary</td>
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<td>Labs</td>
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<td>X-Ray MRI</td>
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<td>Emergency Department Report</td>
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<td>Physician Progress Notes</td>
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<td>Immunization Record</td>
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<td>EKG Tracings</td>
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<td>MRI Report</td>
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<td>Prescription</td>
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<td>Graphic Record</td>
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<td>Operative Report</td>
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This release will be active for 12 months from the date signed.

I understand that information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), and other communicable diseases, Behavioral Health Care/Psychiatric Care, treatment of alcohol and/or drug abuse and genetic testing; my signature authorizes release of any such information. I may refuse to sign this authorization form. I understand that the Community Healthcare Integrated Paramedicine Program/Rio Rico Medical & Fire District will not condition or deny treatment on my signing this authorization. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. I understand that I have a right to receive a copy of this authorization. This Authorization pertains to the dates specified on this Authorization. Unless I revoke this authorization earlier, it will expire 12 months from the date signed. I understand that if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information. I release Rio Rico Medical & Fire District, its employees and agents, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein. I acknowledge receipt and have read and understand the Notice of Health Information Practices regarding my providers participation in The Network, the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy. I understand I am voluntarily participating in the Community Healthcare Integrated Paramedicine Program (CHIPP).

**SIGNATURE OF PARTICIPANT**

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<td>Signature</td>
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**For Office Use Only**

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<td>Date Information Released</td>
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**Participant #:**
Rio Rico Medical and Fire District
Rio Rico, Arizona

Community Healthcare Integrated Paramedicine Program (CHIPP)
Policy Manual

POLICY: Promoting the CHIPP In the Community

POLICY NUMBER: CHIPP 3.3

APPROVED BY: Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Develop and implement a plan for promoting the CHIPP in the community.

POLICY: The CHIPP will develop, implement, and maintain a plan for promoting CHIPP in the community. Such plan will include:

1) A marketing, advertising, or educational campaign in the RRMFD community to raise awareness about the CHIPP, what it is, how it works, and its advantages to certain community members. The campaign will be revised from time to time to seek more effective methods. Methods may include newspaper interviews, press releases, newspaper advertising, information sheets or flyers, posters, radio or television interviews/public service announcements, advertising, etc.

2) Seeking opportunities to distribute information on the CHIPP at schools and work places.

3) A simple procedure for citizens to seek more information on CHIPP, and to enroll in the program, or refer another community member to the program as a possible participant.

4) A method for new CHIPP participant enrollments that are as a result of these efforts to promote information about the CHIPP in the community to be tracked and evaluated in order to help evaluate the success of these efforts to raise community awareness about the CHIPP.
Section 4:
Conducting Participant Visits

4.1 Conducting the First CHIPP Visit
4.2 Conducting a Scheduled CHIPP Visit
4.3 Converting a Scheduled CHIPP Visit to a 911 EMS Call: Decision-making and Procedures
4.4 Medical Equipment Bag for CHIPP
4.5 Medical Supplies and Medical Equipment Issues in the Home
4.6 Reviewing Participant Medications
4.7 The Final CHIPP Visit
4.8 Discharging a CHIPP Participant
Community Healthcare Integrated Paramedicine Program (CHIPP)
Policy Manual

POLICY:
Conducting the First Visit with a New CHIPP Participant

POLICY NUMBER:
CHIPP 4.1

APPROVED BY:
Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S):
10/7/2016

OBJECTIVE:
Develop and implement a plan for conducting the first visit with a new CHIPP participant.

POLICY:
The CHIPP will develop, implement, and maintain a plan for conducting the first visit with a new participant. Such plan will include...

1) Greet and introduce CHIPP care providers. Explain how the CHIPP program works.

2) Obtain participant agreement to participate, and have enrollment form signed (see page 8 of CHIPP Policy #3.2).

3) Complete relevant information on enrollment form.

4) Determine all medical care providers, agencies, and facilities that the participant is associated with. Identify the primary care provider.

5) Assess other resources, and family and other social support systems relevant to the participant’s health status.

6) Assess participant’s education and cognitive functional status.

7) Determine language (English, Spanish, etc.) preference and proficiency.

8) Assess degree of participant’s knowledge about his health problems, readiness to engage in a self-care plan, and...
openness to preventive and wellness activities.

9) Assessment of the primary medical problem(s) of concern.

10) Assessment general health status, and other medical problems.

11) Review medications participant is currently taking. Include prescribed medications, over-the-counter medications, vitamins/minerals/supplements, and herbal and home-remedies. See Policy CHIPP 4.5.

12) Review ongoing medical treatments, medical supplies, and medical equipment used in the home. See Policy CHIPP 4.4.

13) Conduct a home safety review, with particular attention to injury prevention and environmental factors that might affect the participant’s medical status. See Policies CHIPP 9.4 and CHIPP 9.5.

14) Develop an initial CHIPP care plan.

15) Recording findings in the CHIPP medical record.

16) Schedule the next home visit.

17) Provide that participant with information on how to reach the CHIPP program for follow-up questions or concerns.

18) The initial CHIPP visit will be longer than typical visits, generally 1 ½ to 2 hours.

19) Immediately after the initial visit, do further development of the CHIPP care plan.
POLICY: Conducting a Scheduled CHIPP Visit

POLICY NUMBER: CHIPP 4.2

APPROVED BY: Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Develop and implement a plan for conducting a scheduled, routine visit with a CHIPP participant.

POlICY: Though recognizing that all CHIPP participants are unique and have their own special set of medical problems, the scheduled, routine CHIPP visit has a standard format (presented below). Changing participant status and needs will result in more or less emphasis to each of the steps of the typical visit format. Some steps may not be needed at a particular, and some new steps may be added. These alterations to the typical visit structure will be made by the senior CHIPP care provider based on professional judgment.

PROCEDURE:

1. Greeting and introductions.

2. Open each visit with an opportunity for the participant to say how he is doing, bring up any problems or issues, and comment on progress with his medical problem.

3. Take the participant’s vital signs, to include pulse, respiratory rate, and blood pressure. The patient’s temperature may be taken if indicated by the underlying medical problem of concern. Determine the oxygen saturation (SPO2), as indicated (particularly for those with a respiratory and/or cardiac history).

4. Conduct a general participant assessment, with particular focus on the primary medical problem(s). The physical
assessment will focus on a search for signs relevant to the medical problem(s) of concern. Continue with a participant interview to elicit information regarding symptoms of concern. Ask questions about any factors that alleviate or aggravate signs or symptoms.

5. Conduct a participant medication review (see Policy CHIPP 4.6).

6. Be alert to social and physical conditions in the home that might be relevant to the participant’s health status.

7. Ask about his next schedule visit with his primary care provider.

8. Ask about upcoming prescription renewals, scheduled lab test visits, and plans to refresh medical supplies and equipment. Assist in problem-solving if issues are identified that are barriers toward progress.

9. Assist the participant in developing, reviewing, and checking on progress on his medical action plan.

10. Assist the participant in setting health goals, reviewing progress towards meeting goals, celebrate successes, offer encouragement and promote a positive outlook, and help identify new health goals to be added.

11. Talk with the participant about prevention, wellness, health promotion, and efforts towards self-care. Remember to include diet and exercise.

12. In all interactions with the participant, remember to use motivational interviewing techniques.

13. Make appropriate referrals to useful community health resources.

14. Assist the participant in communications with the primary care provider, and other involved health providers.

15. At the end of the visit, ask if there are any other problems, issues, or needs that need to be dealt with.

16. Begin planning together for ultimate discharge from the CHIPP.

17. Schedule the next visit.

18. Initiate any planned referrals.

19. Take action to solve identified problems.

20. On return to the station, update the participant’s CHIPP medical record, record new goals and issues, and take positive steps to communicate to the rest of the CHIPP care team about any issues they should all be alerted to.
POLICY: Converting a Scheduled CHIPP Visit to a 911 EMS Call: Decision-Making and Procedures

POLICY NUMBER: CHIPP 4.3

APPROVED BY: Les Caid, Chief

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Develop and implement a plan Converting a Scheduled CHIPP Visit to a 911 EMS Call, including decision-making parameters, and procedures for carrying out the decision.

POLICY: Guidelines for making the decision for converting a scheduled CHIPP home visit into 911 emergency EMS response include careful adherence to the condition-specific decision algorithms provided by the Base Hospital EMS Medical Director. In addition, CHIPP care providers will assess the acuity and stability of the participant’s clinical status during each CHIPP visit, and if, in the judgment of the senior CHIPP care provider present the participant’s status indicates the need for an EMS response, will immediately initiate a full EMS response. Procedures for activating that response are listed below.

A CHIPP care provider who is a paramedic or EMT with RRMFD, after activating a full EMS response, and while awaiting the arrival of the responding EMS unit, may proceed to provide emergency care to the CHIPP participant (who is now an EMS patient), using normal EMS operational protocols and under the Base Hospital standing orders/algorithms and the SAEMS protocols and standing orders as are typically in place during a normal EMS response (recognizing the reality that full EMS equipment, supplies, and medications may not yet be one the scene).

PROCEDURE FOR ACTIVATING FULL EMS RESPONSE TO A CHIPP PARTICIPANT FOUND TO BE IN NEED OF EMS:

1) Using professional judgment and Base Hospital medical direction decision algorithms, make the decision to convert the scheduled, routine CHIPP home visit into a full EMS response, based on assessment of participant status.
2) Contact the RRMFD Captain on duty using cell phone or radio. Request immediate EMS response. If unable to contact the RRMFD Captain on duty immediately, call 911 and request EMS response.

3) Stay with the participant, providing basic care as indicated until EMS unit arrives and takes over care.

4) Complete appropriate documentation.

5) Ensure that this event is reported to the Base Hospital medical director, or his staff, on the next business day.
Community Healthcare Integrated Paramedicine Program (CHIPP)
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POLICY: Medical Equipment Bag for CHIPP

POLICY NUMBER: CHIPP 4.4

APPROVED BY: Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Define contents of the medical equipment bag for CHIPP visits.

POLICY: The CHIPP medical equipment bag will contain, at a minimum, the following:

1) CHIPP patient care record forms.
2) Pen.
3) Clipboard.
4) CHIPP operational policy manual.
5) CHIPP decision algorithms developed by the Base Hospital Medical Director.
6) Forms and reference materials for common chronic conditions such as asthma, emphysema, COPD, angina, recent MI, diabetes, dementia, etc.
7) Checklists and action-plan forms useful for helping participants to develop a self-care plan for the common chronic conditions.
8) Santa Cruz County community medical resource agencies and phone numbers.
9) Stethoscope (high-quality).
10) Sphygmomanometer.
11) Thermometer.
12) Pulse oximeter with appropriate disposable oximeter peripherals.

13) Glucometer.

14) Cardiac monitor.

15) End-tidal CO₂ monitor (capnography).

16) Fire/EMS portable radio.

17) Scale.

18) Phone.

19) Tablet/Computer
POLICY: Medical Supplies and Medical Equipment Issues in the Home

POLICY NUMBER: CHIPP 4.5

APPROVED BY:

Josh Gaither, MD Associate Base Hospital Medical Director

Les Caid, Chief

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Describe issues that may arise with various types of medical supplies and equipment that may be found in the home, and what the role of the CHIPP provider shall be in dealing with these issues.

POLICY: The CHIPP provider (EMT or paramedic) may assist the CHIPP participant in solving issues related to medical supplies and equipment in the home. Often times this assistance may be no more than helping the participant obtain such needed supplies and equipment, consistent with the medical care plan outlined by the participant’s primary care provider, or in simple problem-solving.

At other times there may be a simple malfunction that needs to be corrected, or a straight-forward problem that needs to be solved. In these cases, the CHIPP provider may assist the participant in solving the problem. Such assistance shall be limited to simple solutions that are consistent with the provider’s knowledge, are not complex, and do not pose any potential dangers to the participant. At all times the CHIPP EMT or paramedic must keep in mind the Arizona EMS “scope of practice” and insure that it is not violated.

Some of the multiple types of medical supply and equipment issues that may arise are presented below, in two sections, with possible actions presented, and examples of situations where the provider should not directly intervene in a hands-on manner. These examples are not complete; other types of supply and equipment issues may arise.

Some devices may be supported by an agent from a durable medical equipment supplier.

In Santa Cruz County, the primary home health care provider is “ Dependable Health Services.” If they are involved in providing home health care to the CHIPP participant, contact them directly with any questions, concerns, or malfunctions. They can be reached at their office number 520-761-3211, or, if necessary, contact Chris Cunanan, RN, MSN, Clinical Supervisor of Dependable Home Health (at any time) via his cell phone 520-954-6674.

Simple Issues, with possible appropriate actions by the CHIPP provider:
**Humidifier** – The participant has been using tap water in the humidifier tank, and scale is building up. The provider may recommend that the operator’s manual be consulted for scale-removal procedures (such as cleanse with vinegar, then rinse), and that the participant or in-home family/care-providers should obtain distilled water for use in the humidifier (if such is recommended in the operator’s manual).

**Oxygen tank** – The tank is nearly empty, and the valve is too tight for the participant to remove. The provider may assist the participant in changing the valve from the nearly-empty to a full oxygen tank, and check for proper function.

**Oxygen concentrator** – The oxygen concentrator has stopped working. The participant may perform simple trouble-shooting such as checking to see that it is plugged in, the machine is in the “open” mode, the re-set button (if any) has been pushed, and the operator’s manual has been consulted for simple trouble-shooting instructions. If these simple actions do not work, the provider may assist the participant in immediately converting to an oxygen tank to continue his oxygen supply, then contacting the supplier for replacement or repair of the oxygen concentrator.

**CPAP / BiPAP** – The device is not making a proper seal on the face. The provider may assist the participant in adjusting the mask fit. The operator’s manual may be consulted for simple trouble-shooting tips.

**Suction machine** – The drainage collecting chamber is full, and the participant is unsure how to deal with it. The provider may teach and/or demonstrate how to empty, clean, and re-install the collection chamber. The operator’s manual may be consulted for simple trouble-shooting tips.

**Foley catheter** – The provider may inspect the Foley catheter for proper function, see that the tube is properly secured so as not to result in tension on the tube, and may re-tape or otherwise secure it properly. The provider may demonstrate to the participant proper technique for emptying urine from the bag, and re-inforce proper sanitary techniques. If the catheter has been pulled out or has fallen out, the provider should assist the participant in contacting the home health nurse (if there is one), or the primary care provider for instructions on how to proceed.

**Wound dressings** – Simple wound dressings can be inspected, and changed or reinforced. The wound can be inspected for signs of healing progress, and possible irritation or infection. If inadequate healing progress is noted, or signs of irritation or infection is present, the provider should contact the home health nurse (if there is one) or the primary care provider (PCP). For more complicated wound dressings, such as those using special bio-engineered dressings, or where complex skin-grafts are present, loose dressings may be reinforced, with a call made to the home health nurse or PCP for further instructions to the participant on how to proceed. See section below for wound vats.

**Incentive spirometer** – The provider may teach and encourage the participant to use his incentive spirometer according to hospital discharge or PCP instructions. The participant simply blows into the tube to elevate the ball to a specified level, for a specified short duration, and at a recommended frequency. This simple device involves few or no dangers.

**Anti-embolic stockings** – The provider may assist the participant in putting the anti-embolic stockings on, according to PCP or hospital discharge instructions. Often, putting these special stockings on is difficult for the participant, especially if the participant is elderly, weak, feeble, obese, has foot/ankle/leg edema, or lacks the flexibility required. Some participants may find them uncomfortable, and are therefore non-compliant in their use. The provider may substitute ace wraps on both legs (starting from the foot up, and checking to make sure they are not too tight). The participant and/or a family member or in-home care provider can be taught how to use ace wraps properly. The participant should be encouraged to move as much as possible, and move the legs frequently (flex and extend the feet, even while seated), to promote leg circulation and help reduce risk of venous thrombosis and the risk of embolism. If lower extremity edema is the issue, in addition to the above steps, encourage the participant to elevate his legs often.
**Glucometer** – Demonstrate proper glucometer use to the participant. Review the operator’s manual, with its precautions, with the participant. Ask the participant to return-demonstrate proper use. Observe participant while he uses the glucometer. Encourage the participant to develop a careful calendar to ensure that he does not run out of test strips.

**Walker or scooter** – Teach participant proper and safe use of the walker. Observe the participant as the walker is used. Make appropriate referrals to assist the participant to obtain a walker or scooter, if indicated. Teach participant simple steps involved, such as making sure the scooter is properly re-charged and maintained. Check out scooter access throughout the home, suggesting or assisting with simple furniture rearrangement or clutter-object or throw-rung removal to make access better. Help participant problem-solve issues such as finding resources for ramp design and installation.

**Complex or complicated Issues, or those with possible dangers or requiring actions outside of the EMS scope of practice, including appropriate actions by the CHIPP provider:**

For complex and potentially-dangerous medical devices, not generally encountered or used by EMS personnel, and devices with which the CHIPP provider is unfamiliar, such as home infusion of medications via a central line, an insulin pump, a home ventilator, a PEG tube, etc., the CHIPP provider should typically offer only general help and support but no hands-on adjustments, manipulations, or changes.

**Central lines or PICC lines** – The CHIPP provider may inspect these lines, to make sure that the dressings are in place and to look for signs of infection. Also observe the participant for any signs of infection (sick, fever, weakness, low urine output, etc.). These lines are typically present for infusion of specific medications. The CHIPP provider will not administer any of these medications through the central line, nor make adjustments in flow, dosage, or frequency. Refer all issues to the home health nurse or PCP.

**Hemodialysis vascular access / A-V shunt** – Inspect only. Report signs of infection to home health nurse or PCP. Do not administer any fluid or medications into this access.

**Naso-gastric tube; Dobhoff tube; feeding tube** – Inspect, apply tape to secure in place properly (if needed). Contact the home health nurse or PCP regarding any reported or observed issues regarding function, occluded tube, tube displacement, irrigating the tube, distended abdomen, abdominal pain, questions regarding tube-feeding regimen, etc. The CHIPP provider should not administer tube feedings. Ask the participant how things are working, how he does feedings, etc. to assess his level of understanding about how the device works, and proper technique. Refer all questions and issues to the home health nurse or PCP. If severe abdominal pain is present (possibly also with abdominal distention), transport to the ED as an EMS case.

**Percutaneous endoscopic gastrostomy (PEG) tube** – This is a tube inserted through the abdominal wall into the stomach, typically for long-term tube feeding. Use of a PEG tube makes use of the more-uncomfortable nasogastric (NG) tube unnecessary. The CHIPP provider may inspect the skin around the tube entrance site for irritation, leakage, and infection. If any of these issues are found, refer the issue to the home health nurse or PCP for immediate attention. Ask the participant questions about how he handles the PEG tube feedings. Refer any questions or issues to the home health nurse or PCP. If the tube has fallen out or is found to be dislodged, do not replace it; simply cover the stoma with a light dressing, then convert to immediate EMS response for transport to the hospital.

**Tube feeding pumps** – Inspect of system integrity and observe/question the participant as to his understand of and proper use of the system. The CHIPP provider should not adjust pump settings nor administer tube feedings. Report any questions, concerns, issues, or malfunctions to the home health nurse or PCP.
Colostomy or urostomy – CHIPP provider may assess participant’s understanding of how the colostomy or urostomy works, proper procedures and techniques, and presence of required supplies. If a leakage or skin irritation problem is reported, inspect. Report any issues to the home health nurse or PCP immediately. If signs of sepsis or bowel obstruction are noted, convert to an immediate EMS response for transport to the hospital.

Supra-pubic catheter – This is a urinary catheter that exits the bladder through the abdominal wall (placed via a surgical procedure) instead of the usual placement through the urethral meatus via the urethra into the bladder. The CHIPP provider may assess participant knowledge and ability to use the catheter properly. Inspect the abdominal exit site for skin irritation or infection. Note if urine is draining properly into the closed-system urine drainage bag. Report questions, concerns, and problems to the home health nurse or PCP. The home health nurse can often fix problems without the necessity of an ED or hospital visit. Observe for sepsis, abdominal distention, abdominal pain, lack of urine flow, or tube displacement – these issues may require immediate EMS transport to the hospital.

Wound vac – This is a special wound seal / dressing to which a drainage tube, under negative pressure, is attached. This system facilitates removal of drainage from the wound and therefore promotes tissue granulation and wound healing. It is often used for open wounds not surgically closed, or for pressure ulcers. The CHIPP provider shall not remove the wound dressing / seal, but may apply simple reinforcement with extra tape if needed. Observe the skin in the immediate area for irritation or infection. A bulb or mechanical pump may be used to maintain negative pressure (low-pressure suction). The CHIPP provider may make sure a non-functioning pump is plugged in and turned on, but otherwise should not adjust any controls or settings. Blood or sero-sanguinous drainage may be observed in the collection container / canister, which could become dislodged or full. If dislodged, simply pop it back into place. The CHIPP participant may know this procedure and be able to do it himself. If the collection canister is full, it should be emptied according to proper procedure (again, this is something the participant should know how to do). The pump might display alarms such as “leak alarm detected” or “resume”. If “resume” is displayed, the participant or the provider may push the “yes” button to resume function. Other pump function issues may be resolved by turning the unit off, then back on, and hitting the “yes” button as indicated. Beyond that, all questions, issues, malfunctions, and other alarms should be reported immediately to the home health nurse or PCP. Do not re-program the pump settings. Most units have a power cable to the wall electrical outlet, plus a back-up battery. At times the battery may go dead and require re-charge. If so, make sure unit is plugged into the wall electrical outlet. Dislodged wound vac dressings may require proper surgical replacement by a physician, and may therefore require a trip to the hospital (depending on the complexity of the wound and tube placement into the wound). Immediately consult the PCP, or transport via EMS to the hospital if such is the case.

Chest tubes – Home chest tubes may be used, particularly for chronic pulmonary effusions such as in lung cancer. The tube is typically sutured to the skin, and the exit site surrounded by petrolatum-impregnated gauze, reinforced with regular split gauze and tape. The CHIPP provider may inspect the site to insure that the dressings remain intact, and to observe for any signs of skin irritation or infection. Inspect that all tube connections are tight and secure. The system must remain a closed system at all times to prevent air from passing through the chest tube into the pulmonary cavity, causing a pneumothorax. The CHIPP provider should not empty the chest drainage container due to risk of losing system integrity and of causing an open pneumothorax. The CHIPP provider should not “strip” or “milk” the drainage tube. Refer all questions and concerns about infection or drainage system integrity to the home health nurse or PCP. Convert to immediate EMS transport for violations of system integrity (chest tube falls out, tubing is disconnected, or for signs of infection or sepsis, or for signs of pneumothorax (dyspnea, poor oxygenation, reduced breath sounds on affected side, etc.)). Immediately close any air-leaks with tape, or place an impermeable dressing over chest wound, use the oximeter, and apply oxygen. Transport immediately via EMS to a hospital for possible open pneumothorax.

Wound drains, Jackson-Pratt (J-P) drains – This is drains from a wound or body cavity, usually sutured into place. The CHIPP provider may inspect for system integrity, and signs of skin irritation or infection. Drainage fluids are often directed into a negative-pressure bulb. The CHIPP provider may assist the participant in opening the bulb vent, draining the collected fluid, then squeezing the bulb to re-set the suction or negative pressure, then occluding the vent. The
character and amount of drainage should be recorded in the participant’s in-home log. Tubing connections may be secured with extra tape. Report questions, concerns, and problems to the home health nurse or PCP immediately. If the tube falls out of the wound, do not replace. Put a simple dressing and tape over the wound, and transport via EMS to the hospital.

**IV medication pumps** – The CHIPP provider may inspect for system function and integrity, and for signs of skin irritation or infection. The provider may assist the participant with a simple pump issue such as making sure it is plugged in, hitting the re-start or “on” button to turn it back on, or making sure all tubing connections are secure. The participant may not administer any medications via this device, hang the medications, or re-adjust any of the pump settings. The wrong pump administration rate, wrong medication, or improper drug concentrations obviously can be very dangerous. Report issues to the home health nurse or PCP immediately. If the participant appears to be suffering from a drug reaction or overdose, convert to an immediate EMS response and transport to the hospital.

**Insulin pumps** – These units may be smaller, battery-powered, and more portable. They administer insulin. The participant should be familiar with its use and with trouble-shooting. The CHIPP participant should not adjust this device in any way. Report issues to the home health nurse or PCP immediately. Signs of hyperglycemia, diabetic ketoacidosis, or hypoglycemia should be handled as an immediate EMS response with transport to the hospital.

**Mechanical ventilator** – Portable or in-home mechanical ventilators may rarely be encountered, often for a high quadriplegic. Personal care providers should be well-acquainted with its use and with trouble-shooting. If required in an emergency situation, the CHIPP participant may assist the personal care provider in suctioning the tracheal tube to remove an obstruction. If a ventilator malfunction is encountered, remove the ventilator and convert to manual bagging and immediately activate a full EMS response.
POLICY: Reviewing Participant Medications

POLICY NUMBER: CHIPP 4.6

APPROVED BY: Josh Gaither, MD Associate Base Hospital Medical Director
Les Caid, Chief

APPROVAL/REVISION DATE(S): 

OBJECTIVE: Since proper use of medications is an important element of general health, the CHIPP care team will regularly assist participants in reviewing their use of medications and compliance with prescribing instructions, help to answer participant questions and concerns about medications, and make referrals to the CHIPP pharmacist about any unresolved medication issues.

POLICY: Starting with the first visit, and at regular visit intervals thereafter, CHIPP personnel will assess participant medication use. Problems or concerns with medications will be referred to the CHIPP pharmacist and/or the primary care provider for resolution.

1) Assess medications that the participant is using. Ask to see his medications, read the labels, and attempt to evaluate if the client is taking the medications as prescribed.

2) Assess with the CHIPP participant the apparent effects of the medications being taken.

3) Ask if the participant has any questions or concerns about the medications. Query the participant about his knowledge of the medications being used.

4) Ask the participant about any perceived side-effects of the medications being taken.

5) Seek to determine if the participant has stopped taking any of his medications, or is taking more than the prescribed amount.

6) Teach the participant about his medications, proper use and prescription compliance, possible side effects, and
proper administration techniques (such as with inhalers, nitroglycerine, etc.).

7) Contact the CHIPP on-call pharmacist, Arizona Poison & Drug Information Center, or the prescribing provider or primary care provider via phone (urgent) or secure email (non-urgent), with medication concerns.

8) Document all assessments and actions in the CHIPP participant record.
Rio Rico Medical and Fire District
Rio Rico, Arizona

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POLICY: The Final CHIPP Visit

POLICY NUMBER: CHIPP 4.7

APPROVED BY: 
Les Caid, Chief

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Insure that participant needs have been met, progress has been made engaging the participant in self-care, and that he is ready for discharge from the CHIPP program at the last scheduled CHIPP home visit; or alternative in-home support has been identified.

POLICY: When progress toward self-care competence has been determined, plans will be made jointly with the participant for his discharge from the CHIPP. A last visit will be scheduled. At that last visit, the CHIPP team will insure that:

1) Remaining participant questions about his health concerns are answered.

2) Plans are in place for continuing participant self-care without continued CHIPP program supervision.

3) The participant articulates good understanding of his health status, understands appropriate prevention steps, and has a plan for continued positive changes in health behaviors that will promote wellness.

4) The participant knows how to contact RRMFD CHIPP in the future if the need arises.

5) Notes are made in the CHIPP participant record regarding all of the above, and the participant’s action plan for continuing health progress after discharge from the CHIPP.

6) Make plans for four follow-up phone calls over four months.

Note that some participants may not reach the desired goals, particularly as far as prevention actions and engagement in positive behavior changes and taking responsibility for self-care are concerned. Complex care needs may persist. But even if maximum CHIPP provider team support has not been entirely successful, particularly when little forward progress is being made, the time for discharge from the CHIPP program may ultimately arrive.
POLICY: Discharging a CHIPP Participant

POLICY NUMBER: CHIPP 4.8

APPROVED BY: Les Caid, Chief
Joshua Gaither, MD

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Define procedures for the discharge process (graduation) of the CHIPP participant.

POLICY: At the planned final visit to a CHIPP participant, specific steps will take place to discharge (or, graduate) the participant from the program. Those steps will include:

1) The final visit by CHIPP personnel to the participant will be conducted. See CHIPP Policy #4.7.

2) Explain to the participant that CHIPP personnel will make four follow-up phone calls over the next four months to see how the participant is maintaining and progressing on his self-goal and wellness goals. After the visit, the four phone call dates will be scheduled in the work calendar. Typically, these follow-up phone calls will be made by the same CHIPP personnel who did the home visits for this participant. The substance of each of these calls will be recorded in the CHIPP medical record for that participant.

3) During the follow-up phone call(s), it is possible that CHIPP personnel may identify a new health-care need suggesting re-enrollment of that participant into the CHIPP. If so, follow the initial enrollment process (see CHIPP Policy #3.2).

4) At the final scheduled visit, just before discharge (graduation), develop with the participant a self-care plan of continued action, including setting wellness goals.

5) Document in the CHIPP medical record details of the last visit, final assessments, the self-care plan of continued action, and that the four follow-up calls have been scheduled.

6) Explain to the participant how to re-contact CHIPP, if it becomes necessary, or if there are questions or concerns to discuss.

7) Celebrate successes and achievement of self-care proficiencies and attainment of wellness and prevention goals, providing encouragement to sustain the self-care plan, that is, “you can do it,” regarding self-care efficacy.

8) There is no discharge (graduation) form to sign; say goodbye, and state that CHIPP personnel are not scheduled to come back, that this is the last visit.
Section 5:
Information Specific to Particular Diseases
5.1 The CHIPP Participant with Diabetes
5.2 The CHIPP Participant with Asthma
5.3 The CHIPP Participant with Emphysema or COPD
5.4 The CHIPP Participant with Hypertension
5.5 The CHIPP Participant with Congestive Heart Failure
5.6 The CHIPP Participant with Recent Myocardial Infarction and/or Angina
5.7 The CHIPP Participant with Dementia
POLICY: The CHIPP Participant with Diabetes

POLICY NUMBER: CHIPP 5.1

APPROVED BY:
Josh Gaither, MD Associate Base Hospital Medical Director
Les Caid, Chief

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Participant’s with diabetes will receive a thorough diabetes-related initial assessment and continued re-assessments at each follow-up visit. Recommendations or actions will be taken as appropriate based on the assessment findings at each visit. The participant will be encouraged to develop a diabetes action plan, and set objectives for improving his diabetes management.

POLICY:
1) CHIPP personnel will conduct a general physical assessment and a thorough diabetes-related assessment at the initial participant visit.

2) A diabetes-related physical assessment will be performed at each participant follow-up visit. The assessment will include taking a full set of vital signs, and measuring the participant’s blood sugar level using a finger-stick glucometer. The assessment will also include a level-of-consciousness assessment. In addition, as history of the occurrence of diabetes-related signs and symptoms since the last visit will be elicited. Also included in the diabetes physical assessment is noting the presence or absence of diabetic ulcers, and foot care status.

3) Physical assessment of other body systems will be performed at each participant follow-up visit, if indicated due to new multiple or new medical issues.

4) A determination will be made, based on the Base Hospital “diabetes algorithm” (see policy CHIPP 7.2.3 “Diabetes Algorithm”), if the regular, scheduled CHIPP visit will continue, or if EMS dispatch is indicated. This algorithm also includes specific directions for possible administration of an oral source of glucose, and re-assessment of the blood sugar level.

5) At each CHIPP visit, a review of diabetes-related events and issues since the last visit will be made.

6) The participant’s medications will be reviewed at each CHIPP visit.
7) Information regarding diabetes medications, diet, and exercise will be provided at each visit, as indicated.

8) CHIPP personnel will assist the participant in developing a personal diabetes action plan.

9) CHIPP personnel will assist the participant in developing personal health improvement objectives, with a focus on diabetes management. Such objectives will include an exercise and diet plan, and a plan for eventual discharge from the CHIPP.

10) At each visit a review will be conducted with the participant of his diabetes action plan.

11) At each visit a review will be conducted with the participant regarding progress on his diabetes and health improvement objectives.

12) The CHIPP personnel will actively use motivational interviewing techniques, and known techniques to encourage positive health behavior change. A focus on wellness will be emphasized at each CHIPP visit.

13) When indicated, referrals will be made by CHIPP personnel to the CHIPP pharmacy consultant, to the participant’s primary care and other medical care providers, and to specific community health resources that may be relevant.

14) Progress toward the CHIPP discharge plan will be assessed. When indicated, the final CHIPP visit will be scheduled.

15) Conduct the final diabetes CHIPP visit, review with the participant means for maintaining improved diabetes control, and carry out other steps defined in CHIPP policies 4.7 “The Final CHIPP Visit” and 4.8 “Discharging a CHIPP Participant.”
POLICY: The CHIPP Participant with Asthma

POLICY NUMBER: CHIPP 5.2

APPROVED BY:  
Josh Gaither, MD Associate Base Hospital Medical Director

Les Caid, Chief

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Participants with asthma will receive a thorough asthma-related initial assessment and continued reassessments at each follow-up visit. Recommendations or actions will be taken as appropriate based on the assessment findings at each visit. The participant will be encouraged to develop an asthma action plan, and set objectives for improving his asthma management.

POLICY:

1) CHIPP personnel will conduct a general physical assessment and a thorough respiratory assessment, with focus on asthma, at the initial participant visit.

2) An asthma-related physical assessment will be performed at each participant follow-up visit. The assessment will include taking a full set of vital signs, and measuring the participant’s oxygen saturation (pulse oximetry). The assessment may include measurement of peak expiratory flow with an appropriate peak flow meter. In addition, an assessment of signs of oxygenation, respiratory effort, presence or absence of coughing and wheezing will be conducted (as well as taking a history about the occurrence of such signs and symptoms since the last visit).

3) Physical assessment of other body systems will be performed at each participant follow-up visit, if indicated due to new multiple or new medical issues.

4) A determination will be made, based on the Base Hospital “asthma algorithm” (see policy CHIPP 7.2.1 “Asthma Algorithm”), if the regular, scheduled CHIPP visit will continue, or if EMS dispatch is indicated.

5) In cooperation with the participant, based on his experience and information from his other medical care providers, the CHIPP personnel will identify relevant asthma triggers for the participant.
6) CHIPP personnel will assist the participant in developing a plan to avoid and/or manage the participant’s asthma and known triggers. This may include steps to manage environmental triggers in the home, at school, or at work.

7) At each CHIPP visit, a review of asthma-related events and issues since the last visit will be made.

8) The participant’s medications will be reviewed at each CHIPP visit.

9) Information regarding asthma medications and proper use of inhalers will be provided at each visit, as indicated.

10) CHIPP personnel will assist the participant in developing a personal asthma action plan.

11) CHIPP personnel will assist the participant in developing personal health improvement objectives, with a focus on asthma management. Such objectives will include an exercise plan, and a plan for eventual discharge from the CHIPP.

12) At each visit a review will be conducted with the participant of his asthma action plan.

13) At each visit a review will be conducted with the participant regarding progress on his asthma and health improvement objectives.

14) When indicated, referrals will be made by CHIPP personnel to the CHIPP pharmacy consultant, to the participant’s primary care and other medical care providers, and to specific community health resources that may be relevant.

15) Progress toward the CHIPP discharge plan will be assessed. When indicated, the final CHIPP visit will be scheduled.

16) Conduct the final asthma CHIPP visit, review with the participant means for maintaining improved asthma status, and carry out other steps defined in CHIPP policies 4.7 “The Final CHIPP Visit” and 4.8 “Discharging a CHIPP Participant.”
POLICY: The CHIPP Participant with Emphysema or COPD

POLICY NUMBER: CHIPP 5.3

APPROVED BY: Josh Gaither, MD Associate Base Hospital Medical Director
Les Caid, Chief

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Participant’s with emphysema of chronic obstructive pulmonary disease (COPD) will receive a thorough respiratory-related initial assessment and continued re-assessments at each follow-up visit. Recommendations or actions will be taken as appropriate based on the assessment findings at each visit. The participant will be encouraged to develop an emphysema or COPD action plan, and set objectives for improving his respiratory status.

POLICY:
1) CHIPP personnel will conduct a general physical assessment and a thorough respiratory-related assessment at the initial participant visit.

2) A respiratory-related physical assessment will be performed at each participant follow-up visit. The assessment will include taking a full set of vital signs, and measuring the participant’s oxygen saturation level with a pulse oximeter. In addition, a history of the occurrence of COPD-related signs and symptoms (including chest pain, increased dyspnea, orthopnea, cough, frothy sputum, or other respiratory sign) since the last visit will be elicited.

3) Physical assessment of other body systems will be performed at each participant follow-up visit, if indicated due to new multiple or new medical issues.

4) A determination will be made, based on the Base Hospital “COPD algorithm” (see policy CHIPP 7.2.2 “COPD Algorithm”), if the regular, scheduled CHIPP visit will continue, or if EMS dispatch is indicated. This algorithm also includes specific directions for assisting the participant with using his own Albuterol inhaler, when indicated by an oxygen saturation <88 or increased dyspnea, and then performing a re-assessment of the oxygen saturation for improvement (>87) prior to the decision to dispatch EMS.

5) At each CHIPP visit, a review of COPD-related events and issues since the last visit will be made.

6) The participant’s medications will be reviewed at each CHIPP visit.
7) Information regarding respiratory medications will be provided at each visit, as indicated.

8) CHIPP personnel will assist the participant in developing a personal COPD action plan.

9) CHIPP personnel will assist the participant in developing personal health improvement objectives, with a focus on COPD management. Such objectives will include an exercise and diet plan, and a plan for eventual discharge from the CHIPP.

10) At each visit a review will be conducted with the participant of his COPD action plan.

11) At each visit a review will be conducted with the participant regarding progress on his COPD and health improvement objectives.

12) The CHIPP personnel will actively use motivational interviewing techniques, and known techniques to encourage positive health behavior change. A focus on wellness will be emphasized at each CHIPP visit.

13) When indicated, referrals will be made by CHIPP personnel to the CHIPP pharmacy consultant, to the participant’s primary care and other medical care providers, and to specific community health resources that may be relevant.

14) Progress toward the CHIPP discharge plan will be assessed. When indicated, the final CHIPP visit will be scheduled.

15) Conduct the final COPD CHIPP visit, review with the participant means for maintaining improved COPD control, and carry out other steps defined in CHIPP policies 4.7 “The Final CHIPP Visit” and 4.8 “Discharging a CHIPP Participant.”
POLICY: The CHIPP Participant with Hypertension

POLICY NUMBER: CHIPP 5.4

APPROVED BY:  
Josh Gaither, MD Associate Base Hospital Medical Director

Les Caid, Chief

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Participant’s with a history of hypertension (often in addition to another primary health issue that may be the reason for enrolling in the CHIPP) will receive a thorough hypertension-related initial assessment and continued re-assessments at each follow-up visit. Recommendations or actions will be taken as appropriate based on the assessment findings at each visit. The participant will be encouraged to develop a hypertension action plan, and set objectives for improving his blood pressure control.

POLICY:
1) CHIPP personnel will conduct a general physical assessment and a thorough hypertension-related assessment at the initial participant visit.

2) A hypertension-related physical assessment will be performed at each participant follow-up visit. The assessment will include taking a full set of vital signs, and taking a history of the occurrence of hypertension-related signs and symptoms (elevated blood pressure, headache, any change in hypertension medications).

3) Physical assessment of other body systems will be performed at each participant follow-up visit, if indicated due to new multiple or new medical issues.

4) A determination will be made, based on the Base Hospital “hypertension algorithm” (see policy CHIPP 7.2.4 “HTN Algorithm”), if the regular, scheduled CHIPP visit will continue, or if EMS dispatch is indicated.

5) At each CHIPP visit, a review of hypertension-related events and issues since the last visit will be made.

6) The participant’s medications will be reviewed at each CHIPP visit.

7) Information regarding use of hypertension medications will be provided at each visit, as indicated.
8) CHIPP personnel will assist the participant in developing a personal hypertension action plan.

9) CHIPP personnel will assist the participant in developing personal health improvement objectives, with a focus on hypertension management. Such objectives will include an exercise and diet plan, and a plan for eventual discharge from the CHIPP.

10) At each visit a review will be conducted with the participant of his hypertension action plan.

11) At each visit a review will be conducted with the participant regarding progress on his hypertension and health improvement objectives.

12) The CHIPP personnel will actively use motivational interviewing techniques, and known techniques to encourage positive health behavior change. A focus on wellness will be emphasized at each CHIPP visit.

13) When indicated, referrals will be made by CHIPP personnel to the CHIPP pharmacy consultant, to the participant’s primary care and other medical care providers, and to specific community health resources that may be relevant.

14) Progress toward the CHIPP discharge plan will be assessed. When indicated, the final CHIPP visit will be scheduled.

15) Conduct the final CHIPP visit, review with the participant means for maintaining improved hypertension control, and carry out other steps defined in CHIPP policies 4.7 “The Final CHIPP Visit” and 4.8 “Discharging a CHIPP Participant.”
OBJECTIVE: Participant’s with a history of congestive heart failure (CHF) will receive a thorough CHF-related initial assessment and continued re-assessments at each follow-up visit. Recommendations or actions will be taken as appropriate based on the assessment findings at each visit. The participant will be encouraged to develop a CHF action plan, and set objectives for improving his heart failure status.

POLICY:
1) CHIPP personnel will conduct a general physical assessment and a thorough CHF-related assessment at the initial participant visit.

2) A CHF-related physical assessment will be performed at each participant follow-up visit. The assessment will include taking a full set of vital signs, determining the oxygen saturation via pulse oximetry, weighing the participant, and taking a history of the occurrence of CHF-related signs and symptoms (weight change, increased dyspnea, orthopnea, coughing, frothy sputum, chest pain, increased shortness of breath on exertion, and any change in CHF medications).

3) Physical assessment of other body systems will be performed at each participant follow-up visit, if indicated due to new multiple or new medical issues.

4) A determination will be made, based on the Base Hospital “CHF algorithm” (see policy CHIPP 7.2.5 “CHF Algorithm”), if the regular, scheduled CHIPP visit will continue, or if EMS dispatch is indicated.

5) At each CHIPP visit, a review of CHF-related events and issues since the last visit will be made.

6) The participant’s medications will be reviewed at each CHIPP visit.

7) Information regarding use of CHF medications will be provided at each visit, as indicated.
8) CHIPP personnel will assist the participant in developing a personal CHF action plan.

9) CHIPP personnel will assist the participant in developing personal health improvement objectives, with a focus on CHF management. Such objectives will include an exercise and diet plan, and a plan for eventual discharge from the CHIPP.

10) At each visit a review will be conducted with the participant of his CHF action plan.

11) At each visit a review will be conducted with the participant regarding progress on his CHF and health improvement objectives.

12) The CHIPP personnel will actively use motivational interviewing techniques, and known techniques to encourage positive health behavior change. A focus on wellness will be emphasized at each CHIPP visit.

13) When indicated, referrals will be made by CHIPP personnel to the CHIPP pharmacy consultant, to the participant’s primary care and other medical care providers, and to specific community health resources that may be relevant.

14) Progress toward the CHIPP discharge plan will be assessed. When indicated, the final CHIPP visit will be scheduled.

15) Conduct the final CHF CHIPP visit, review with the participant means for maintaining improved CHF management, and carry out other steps defined in CHIPP policies 4.7 “The Final CHIPP Visit” and 4.8 “Discharging a CHIPP Participant.”
Community Healthcare Integrated Paramedicine Program (CHIPP)
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POLICY:
The CHIPP Participant with Recent Myocardial Infarction and/or Angina

POLICY NUMBER:
CHIPP 5.6

APPROVED BY:
Josh Gaither, MD Associate Base Hospital Medical Director
Les Caid, Chief

APPROVAL/REVISION DATE(S):
10/7/2016

OBJECTIVE: Participant’s with a history angina or recent myocardial infarction (MI) will receive a thorough angina/recent MI-related initial assessment and continued re-assessments at each follow-up visit. Recommendations or actions will be taken as appropriate based on the assessment findings at each visit. The participant will be encouraged to develop an angina/recent MI action plan, and set objectives for improving his heart status.

POLICY:
1) CHIPP personnel will conduct a general physical assessment and a thorough angina/recent MI-related assessment at the initial participant visit.

2) An angina/recent MI-related physical assessment will be performed at each participant follow-up visit. The assessment will include taking a full set of vital signs, determining the oxygen saturation via pulse oximetry, weighing the participant, and taking a history of the occurrence of angina/recent MI-related signs and symptoms (chest pain, weight change, increased dyspnea, orthopnea, coughing, frothy sputum, increased shortness of breath on exertion, palpitations, and any change in cardiac medications).

3) Physical assessment of other body systems will be performed at each participant follow-up visit, if indicated due to new multiple or new medical issues.

4) A determination will be made, based on the Base Hospital “recent MI algorithm” (see policy CHIPP 7.2.6 “Recent MI Algorithm”), if the regular, scheduled CHIPP visit will continue, or if EMS dispatch is indicated.

5) At each CHIPP visit, a review of cardiac-related events and issues since the last visit will be made.

6) The participant’s medications will be reviewed at each CHIPP visit.

7) Information regarding use of heart medications will be provided at each visit, as indicated.
8) CHIPP personnel will assist the participant in developing a personal angina/recent MI action plan.

9) CHIPP personnel will assist the participant in developing personal health improvement objectives, with a focus on angina/recent MI management. Such objectives will include an exercise and diet plan, and a plan for eventual discharge from the CHIPP.

10) At each visit a review will be conducted with the participant of his angina/recent MI action plan.

11) At each visit a review will be conducted with the participant regarding progress on his angina/recent MI and health improvement objectives.

12) The CHIPP personnel will actively use motivational interviewing techniques, and known techniques to encourage positive health behavior change. A focus on wellness will be emphasized at each CHIPP visit.

13) When indicated, referrals will be made by CHIPP personnel to the CHIPP pharmacy consultant, to the participant’s primary care and other medical care providers, and to specific community health resources that may be relevant.

14) Progress toward the CHIPP discharge plan will be assessed. When indicated, the final CHIPP visit will be scheduled.

15) Conduct the final angina/recent MI CHIPP visit, review with the participant means for maintaining improved angina/recent MI management, and carry out other steps defined in CHIPP policies 4.7 “The Final CHIPP Visit” and 4.8 “Discharging a CHIPP Participant.”
Community Healthcare Integrated Paramedicine Program (CHIPP)  
Policy Manual

POLICY:  
The CHIPP Participant with Dementia

POLICY NUMBER:  
CHIPP 5.7

APPROVED BY:  
Josh Gaither, MD Associate Base Hospital Medical Director  
Les Caid, Chief

APPROVAL/REVISION DATE(S):  
10/7/2016

OBJECTIVE:  Participant’s with a history of Alzheimer’s Disease or other dementia will receive a dementia-related initial assessment and continued re-assessments at each follow-up visit. Recommendations or actions will be taken as appropriate based on the assessment findings at each visit. The participant and care-givers will be encouraged to develop a dementia action plan, and set objectives for effectively dealing with and living with dementia.

POLICY:  
1) CHIPP personnel will conduct a general physical assessment and a thorough dementia-related assessment at the initial participant visit. General questions regarding dementia are included in the CHIPP intake questionnaire with recommended action planning steps.

2) A dementia-related physical assessment will be performed at each participant follow-up visit. The assessment will include taking a full set of vital signs, and taking a history of the occurrence of dementia-related signs, symptoms, events, and behaviors since the previous visit.

3) Physical assessment of other body systems will be performed at each participant follow-up visit, if indicated due to new multiple or new medical issues.

4) At each CHIPP visit, a review of dementia-related events and issues since the last visit will be made.

5) The participant’s medications will be reviewed at each CHIPP visit.

6) Information regarding use of dementia-related medications will be provided at each visit, as indicated.

7) CHIPP personnel will assist the participant and care-givers in developing a personal dementia action plan (through connection to Alzheimer’s/Dementia resources).
8) CHIPP personnel will assist the participant in developing personal health improvement objectives, with a focus on dementia management. Such objectives will include an exercise and diet plan, a safety and “wandering” plan, a plan for managing routine activities of daily living, and a plan for eventual discharge from the CHIPP (namely though linkage to community resources/PCP).

9) At each visit a review will be conducted with the participant of his dementia action plan.

10) At each visit a review will be conducted with the participant regarding progress on his dementia and health improvement objectives.

11) The CHIPP personnel will actively use motivational interviewing techniques, and known techniques to encourage positive health behavior change. A focus on wellness will be emphasized at each CHIPP visit.

12) When indicated, referrals will be made by CHIPP personnel to the CHIPP pharmacy consultant, to the participant’s primary care and other medical care providers, and to specific community health resources that may be relevant.

13) Progress toward the CHIPP discharge plan will be assessed. When indicated, the final CHIPP visit will be scheduled.

14) Conduct the final dementia CHIPP visit, review with the participant and care providers means for maintaining improved dementia management, and carry out other steps defined in CHIPP policies 4.7 “The Final CHIPP Visit” and 4.8 “Discharging a CHIPP Participant.”
Section 6: Record-Keeping

6.1 CHIPP Record-Keeping
6.2 The CHIPP Medical Record
6.3 The CHIPP Register and Database
Rio Rico Medical and Fire District
Rio Rico, Arizona

Community Healthcare Integrated Paramedicine Program (CHIPP)
Policy Manual

POLICY: CHIPP Record-Keeping

POLICY NUMBER: CHIPP 6.1

APPROVED BY:

Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: A record will be kept at each home visit or other participant contact, of all assessments, observations, actions taken, and participant responses.

POLICY: A standard CHIPP participant record form or format will be developed and implemented. It may be revised, as indicated, from time to time. Simplicity and ease-of-use will be a goal in the design of the form. Some general record-keeping principles include:

1) Document all contacts with the participant. Treat this as a medical record.

2) All form entries will be dated, timed, and signed by the provider writing the entry.

3) Documentation of previous participant contacts will be kept available to the CHIPP care team for review during all subsequent contacts and home visits.

4) Vital signs consisting of blood pressure, pulse rate, and respiratory rate will be made at each home visit. If such vital signs are not indicated for a particular reason, then that reason should be recorded.

5) Other vital signs should be measured and recorded when indicated (temperature, oxygen saturation, etc.)

6) Patient weight will be recorded if it is a concern given the patient’s underlying health issues (for instance in congestive heart failure, participant taking diuretics, obesity or in a weight-loss program, frailty or poor nutrition status, etc.)

7) Document all assessments (physical, mental, psychosocial, behavioral, etc.).

8) Document findings at each visit regarding the identified central health concerns.

9) Document goals, objectives, action plans, prevention plans, and desired health behavior changes.
10) Document participant’s perceived attitudes toward his health status and any action plans developed, as well as apparent progress toward his engagement with self-care.

11) If particular motivational efforts toward engaging the participant in positive wellness and prevention behaviors seem to be successful, note these in the record.

12) Document all actions taken to communicate and coordinate care with other involved care providers such as in-home care providers, Promotoras, home-health personnel, primary care providers, other medical care providers or agencies, contact with community health resources, the CHIPP on-call pharmacist, etc.

13) Complete all entries in the CHIPP participant record on the day of the contact, visit, or coordination/communication occurs.

14) The participant should be allowed to see his record if he desires.

15) Steps toward CHIPP discharge planning should be documented.

16) Details of the final visit should be documented. See CHIPP policy # 4.7.

17) The record remains the property of the RRMFD.
COMMUNITY HEALTHCARE INTEGRATED PARAMEDICINE PROGRAM (CHIPP)  
POLICY MANUAL

POLICY:  The CHIPP Medical Record

POLICY NUMBER:  CHIPP 6.2

APPROVED BY:  [Signature]

APPROVAL/REVISION DATE(S):  10/7/2016

OBJECTIVE:  Maintain a medical record of the CHIPP participant.

POLICY:  A medical record will be maintained for the CHIPP participant, including the signed participant consent form, records of the initial visit, records of each follow-up visit and participant contact or communication, record of the final visit, records of follow-up calls after graduation from the CHIPP program, records of any referrals made, and the medication review.

The paper record will be maintained in a binder in a locked cabinet.

In the near future, CHIPP records will be maintained via the “Practice Fusion” Electronic Health Record platform. At that time, all CHIPP-related notes and referrals will be maintained in this HIPPA-compliant, cloud-based platform.

Whether the CHIPP medical record is hand-written or computerized, the following will apply:

1) The CHIPP participant may examine the record at his request any time.

2) The record is owned by Rio Rico Medical and Fire District.

3) The CHIPP participant record will be treated as are typical medical records in other medical practice environments.

4) The medical record and its content at confidential and will be handled in a HIPPA-compliant manner.

5) Appropriate security safeguards will be maintained to protect the record.

6) Each entry made in the record by a CHIPP staff member will be signed by the person making the entry, and the entry will be dated and timed.

7) Completeness is an important concept in the record, and it should include the signed participant enrollment form and consent, relevant and important details about each visit, assessment findings including vital signs, recommendations made, actions taken, progress being made, comments about which methods of participant encouragement and support
seem to work best, communications with other health care providers about the participant, referrals made to other agencies or providers or community health resources, plans for discharge (graduation), the last visit, other communications with the participant, and notes on the planned four follow-up phone calls after discharge (graduation).

8) Entries into the record should be on the same day as the participant contact. Any late entries should be so noted.
Community Healthcare Integrated Paramedicine Program (CHIPP)
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POLICY: The CHIPP Register and Database

POLICY NUMBER: CHIPP 6.3

APPROVED BY: ________________________________
Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: A well-designed and maintained database of information about the CHIPP is an invaluable tool in assessing the overall success of the CHIPP, and in identifying areas of possible quality concern. In addition, data from such as database is needed for administrative reporting requirement, and making effective management decisions. Such a database is also a rich resource for research in community paramedicine.

POLICY: A carefully-designed computerized database, or register, will be implemented and maintained for the CHIPP. Entered data will be accurate and useful in register output. Principles involved in the design, maintenance, and use of the register include

1) Data elements will be carefully selected, and will be included only when there is clear indication of their use in developing register output reports. Data elements will be thoroughly defined to avoid ambiguity or need for interpretation.

2) A data dictionary will be written and maintained with the definitions of all data elements.

3) Any codes used with a specific data element will be clearly defined, and included in the data dictionary. For example, if one data element is “sex,” the defined codes for entering the data might be: M = male, F = female, O = other (transgender, ambiguous, undetermined, or participant declines to say, etc.), U = unknown or data not available. Alternatively, the codes M, F, O, and U could be: 1, 2, 3, 4. Whichever codes or choices are decided upon, they should be clearly defined, and typically include an option for “unknown or data not available” and “not applicable.”

4) Careful consideration should be given to choices and codes to be used for underlying medical diagnosis data element categories. Comprehensive and sophisticated such as use of ICD-10 would be an advantage, however may be too complex to administer (due to technical competence need in the encoding process). A simplified list of broad medical diagnosis categories might be chosen instead, but will require careful thought and definition.

5) A plan will be developed and implemented regarding entry of data into the register.
6) Programs will be developed to automatically alert to internally inconsistent data entries.

7) Other mechanisms to insure quality of data entry will be developed.

8) Standard data output reports will be developed.

9) Processes and responsibility for development of new or custom data output reports will be developed.

10) Procedures to insure integrity and security of the register, access to it only by authorized individuals, who is authorized to make changes to previously-entered data, who can produce report or other output, and such will be developed.

11) Plans for register system computer maintenance will be made.

12) Procedures for making changes in data elements, codes used, the data dictionary, etc. will be developed.

13) All changes to the data elements and codes will be recorded immediately in the data dictionary.
Section 7:
Medical Direction
7.1 CHIPP Medical Direction Plan
7.2 CHIPP Clinical Decision Algorithms
7.2.1 Asthma Algorithm
7.2.2 COPD Algorithm
7.2.3 Diabetes Algorithm
7.2.4 Hypertension Algorithm
7.2.5 Congestive Heart Failure Algorithm
7.2.6 Recent Myocardial Infarction Algorithm
Community Healthcare Integrated Paramedicine Program (CHIPP)  
Policy Manual

POLICY:  
CHIPP Medical Direction Plan

POLICY NUMBER:  
CHIPP 7.1

APPROVED BY:  
Josh Gaither, MD  
Associate Base Hospital Medical Director  
Les Caid, Chief

APPROVAL/REVISION DATE(S):  
10/7/2016

OBJECTIVE:  
The medical director of the RRMFD’s EMS division will also serve as the medical director of the CHIPP.

POLICY:  
Authority for CHIPP EMTs and Paramedics derives from the CHIPP administrative medical director. The administrative medical director or their designee will set all medical policy for CHIPP, define actions allowed, and develop decision-making algorithms. Actions of the administrative medical director or their designee will be consistent with rules and regulations developed by the Bureau of Emergency Medical Services and Trauma System of the Arizona Department of Health Services, and by applicable Arizona Revised Statutes.

1) The administrative medical director or their designee will define allowed actions to be taken by EMTs and Paramedics within the CHIPP, such being consistent with EMT and Paramedic scope of practice in Arizona.

2) The administrative medical director, and base hospital personnel working in conjunction with the medical director, will review the quality of care provided by CHIPP personnel, and evaluate consistency of actions with defined scope of practice, base hospital regulations and directives, and compliance with applicable decision algorithms.

3) The administrative medical director and their designee reserve the authority to remove practice authorization for individual EMTs or Paramedics in the CHIPP program due to quality of care concerns, or issues with non-compliance with base hospital regulations, directives, decision algorithms, ADHS rules/regulations, or Arizona law.
4) CHIPP staff may consult at any time with the medical director, or authorized medical director surrogate, regarding medical decisions.

5) CHIPP providers may contact the administrative medical director or their designated source of on-line medical direction at any time there is a concern regarding individual patient care.
Community Healthcare Integrated Paramedicine Program (CHIPP)
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POLICY: CHIPP Clinical Decision Algorithms

POLICY NUMBER: CHIPP 7.2

APPROVED BY:  
Josh Gaither, MD Associate Base Hospital Medical Director
Les Caid, Chief

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Clinical decision algorithms will be written and authorized by the base hospital medical director for CHIPP, and will service to guide CHIPP personnel decisions in complex situations.

POLICY: Clinical decision algorithms authorized by the base hospital medical director for CHIPP will be followed in applicable situations by CHIPP personnel. The algorithms will include ones specifically for decision-making when participant medical condition might indicate the need to convert a routine, scheduled CHIPP visit into a full EMS ambulance response. Additional clinical decision algorithms specific to the CHIPP may also be developed and implemented.

Actual occurrence of the use of an existing algorithm to make the decision to convert a routine, scheduled CHIPP home visit into a full EMS response will be identified, and relevant information about that clinical decision and its compliance with the existing decision algorithms will be forwarded to the base hospital medical director for review.
POLICY: CHIPP Asthma Algorithm

POLICY NUMBER: CHIPP 7.2.1

APPROVED BY: Josh Gaither, MD Associate Base Hospital Medical Director
Les Caid, Chief

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Provide a decision-making algorithm for CHIPP participants with asthma, particularly for use in deciding if the participant remains stable for a routine CHIPP home visit, or if the participant’s condition is unstable or of increased acuity requiring immediate EMS dispatch.

POLICY: CHIPP personnel will apply the asthma decision-making algorithm to all CHIPP participants who have asthma, and apply it to each scheduled CHIPP visit. Attached is a current copy of the asthma algorithm provided by the Base Hospital Medical Director.

CHIPP personnel may, at their discretion and using their best clinical judgment, decide to convert a scheduled CHIPP home visit to an immediate EMS response even if the parameters of the decision algorithm are not technically met, if in the clinical judgment of the senior CHIPP care provider present, it would be in the participant’s best interest to do so. In addition, if the CHIPP participant himself requests or insists on an immediate EMS response, then such response will be activated.

See attached “Asthma Patient Care” decision algorithm.
If Sat < 88 or increased dyspnea
- Assist pt with home Albuterol MDI

IF \( O_2 \) Sat Remains < 88 or SBP < 90
- EMS Patient
  - Initiate EMS pt care & transport using appropriate SO OR Call for online medical direction

IF \( O_2 \) Sat Improves Sat > 87 & SBP > 90
- CIP Patient
  - Assist the patient in scheduling an appointment with their PCP within 72hrs and schedule a CIP re-check in 24hr

No change or improvement in dyspnea from baseline
- CIP Patient
  - Routine CIP Visit

Exacerbation of dyspnea from baseline
- CIP Patient
  - Assist the patient in scheduling an appointment with their PCP within 72hrs and schedule a CIP re-check in 24hr

No change from pt's baseline vital signs
- EMS Patient
  - New complaint such as: CP, Near-syncope or syncope, or any other complaint that meets inclusion criteria for any EMS SO that would indicate an EMS intervention is warranted

Special Note: If a CIP patient is identified as an EMS patient and refuses EMS patient care. That patient should be informed that they will continue to receive CIP services. The CIP provider should call the patients primary care provider to schedule an urgent appointment and schedule a re-check in 24hrs
Community Healthcare Integrated Paramedicine Program (CHIPP)

Policy Manual

**POLICY:**

CHIPP COPD Algorithm

**POLICY NUMBER:**

CHIPP 7.2.2

**APPROVED BY:**

Josh Gaither, MD Associate Base Hospital Medical Director

Les Caid, Chief

**APPROVAL/REVISION DATE(S):**

**OBJECTIVE:**

Provide a decision-making algorithm for CHIPP participants with COPD or emphysema, particularly for use in deciding of the participant remains stable for a routine CHIPP home visit, or if the participant’s condition is unstable or of increased acuity requiring immediate EMS dispatch.

**POLICY:**

CHIPP personnel will apply the COPD decision-making algorithm to all CHIPP participants who have emphysema, chronic bronchitis, or COPD, and apply it to each scheduled CHIPP visit. Attached is a current copy of the COPD algorithm provided by the Base Hospital Medical Director.

CHIPP personnel *may*, at their discretion and using their best clinical judgment, decide to convert a scheduled CHIPP home visit to an immediate EMS response even if the parameters of the decision algorithm are not technically met, if in the clinical judgment of the senior CHIPP care provider present, it would be in the participant’s best interest to do so. In addition, if the CHIPP participant himself requests or insists on an immediate EMS response, then such response will be activated.

See attached “COPD Patient Care” decision algorithm.
University of Arizona
Community Integrated Paramedic
COPD Patient Care

If Sat < 88 or increased dyspnea
- Assist pt with home Albuterol MDI
- Ensure home O₂ is working

No change or improvement in dyspnea from baseline

Exacerbation of dyspnea from baseline

New complaint such as: CP, Near-syncope or syncope, or any other complaint that meets inclusion criteria for any EMS SO that would indicate an EMS intervention is warranted

O Sat 88
SBP 90

IE O₂ Sat Remains < 89 or SBP < 90
IF O₂ Sat Improves Sat > 87 & SBP > 90

CIP Patient

CIP Patient

Initiate EMS pt Care & transport using appropriate SO OR Call for online medical direction

Assist the patient in scheduling an appointment with their PCP within 72hrs and schedule a CIP re-check in 24hr

Assist the patient in scheduling an appointment with their PCP within 72hrs and schedule a CIP re-check in 24hr

Special Note: If a CIP patient is identified as an EMS patient and refuses EMS patient care. That patient should be informed that they will continue to receive CIP services. The CIP provider should call the patients primary care provider to schedule an urgent appointment and schedule a re-check in 24hrs
Rio Rico Medical and Fire District
Rio Rico, Arizona

Community Healthcare Integrated Paramedicine Program (CHIPP)
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POLICY: CHIPP Diabetes Algorithm

POLICY NUMBER: CHIPP 7.2.3

APPROVED BY: Josh Gaither, MD Associate Base Hospital Medical Director
Les Caid, Chief

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Provide a decision-making algorithm for CHIPP participants with diabetes, particularly for use in deciding if the participant remains stable for a routine CHIPP home visit, or if the participant’s condition is unstable or of increased acuity requiring immediate EMS dispatch.

POLICY: CHIPP personnel will apply the diabetes decision-making algorithm to all CHIPP participants who have diabetes, and apply it to each scheduled CHIPP visit. Attached is a current copy of the diabetes algorithm provided by the Base Hospital Medical Director.

CHIPP personnel may, at their discretion and using their best clinical judgment, decide to convert a scheduled CHIPP home visit to an immediate EMS response even if the parameters of the decision algorithm are not technically met, if in the clinical judgment of the senior CHIPP care provider present, it would be in the participant’s best interest to do so. In addition, if the CHIPP participant himself requests or insists on an immediate EMS response, then such response will be activated.

See attached “Diabetic Patient Care” decision algorithm.
FSBG < 60 or Symptomatic Hypoglycemia

- Normal mentation & able to tolerate PO
  - CIP Patient
  - Provide PO glucose source and re-check in 30 minutes.
    - Unimproved (FSBG < 100)
      - EMS Patient
      - Ask Patient to call their PCP for instructions & document instructions given. If patient is unable to contact PCP call base hospital for online medical direction
    - Improved (FSBG > 100)
      - CIP Patient

FSBG 60 – 300 Asymptomatic

- Patient Asymptomatic
  - Routine CIP Visit

FSBG > 300

- EMS Patient
  - YES
  - CIP Patient
  - Assist the patient in scheduling an appointment with their PCP within 72hrs and schedule a CIP re-check in 24hrs
  - No
  - EMS Patient
    - Transport to ED or Call for online Medical Direction

Special Note: If a CIP patient is identified as an EMS patient and refuses EMS patient care. That patient should be informed that they will continue to receive CIP services. The CIP provider should call the patient's primary care provider to schedule an urgent appointment and schedule a re-check in 24hrs.
Community Healthcare Integrated Paramedicine Program (CHIPP)
Policy Manual

POLICY:
CHIPP Hypertension Algorithm

POLICY NUMBER:
CHIPP 7.2.4

APPROVED BY:
Josh Gaither, MD Associate Base Hospital Medical Director
Les Caid, Chief

APPROVAL/REVISION DATE(S):
10/7/2016

OBJECTIVE:
Provide a decision-making algorithm for CHIPP participants with hypertension, particularly for use in deciding of the participant remains stable for a routine CHIPP home visit, or if the participant’s condition is unstable or of increased acuity requiring immediate EMS dispatch.

POLICY:
CHIPP personnel will apply the hypertension decision-making algorithm to all CHIPP participants who have hypertension, and apply it to each scheduled CHIPP visit. Attached is a current copy of the hypertension algorithm provided by the Base Hospital Medical Director.

CHIPP personnel may, at their discretion and using their best clinical judgment, decide to convert a scheduled CHIPP home visit to an immediate EMS response even if the parameters of the decision algorithm are not technically met, if, in the clinical judgment of the senior CHIPP care provider present, it would be in the participant’s best interest to do so. In addition, if the CHIPP participant himself requests or insists on an immediate EMS response, then such response will be activated.

See attached “HTN Patient Care” decision algorithm.
Special Note: If a CIP patient is identified as an EMS patient and refuses EMS patient care. That patient should be informed that they will continue to receive CIP services. The CIP provider should call the patients primary care physician to schedule an urgent appointment and schedule a re-check in 24hrs.
POLICY: CHIPP Congestive Heart Failure Algorithm

POLICY NUMBER: CHIPP 7.2.5

APPROVED BY: Josh Gaither, MD Associate Base Hospital Medical Director
Les Caid, Chief

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Provide a decision-making algorithm for CHIPP participants with congestive heart failure, particularly for use in deciding of the participant remains stable for a routine CHIPP home visit, or if the participant’s condition is unstable or of increased acuity requiring immediate EMS dispatch.

POLICY: CHIPP personnel will apply the congestive heart failure decision-making algorithm to all CHIPP participants who have congestive heart failure, and apply it to each scheduled CHIPP visit. Attached is a current copy of the congestive heart failure algorithm provided by the Base Hospital Medical Director.

CHIPP personnel may, at their discretion and using their best clinical judgment, decide to convert a scheduled CHIPP home visit to an immediate EMS response even if the parameters of the decision algorithm are not technically met, if in the clinical judgment of the senior CHIPP care provider present, it would be in the participant’s best interest to do so. In addition, if the CHIPP participant himself requests or insists on an immediate EMS response, then such response will be activated.

See attached “CHF Patient Care” decision algorithm.
University of Arizona
Community Integrated Paramedic
CHF Patient Care

- O2 Sat < 90
  SBP <90
  RR> 19
  
  **EMS Patient**

  - Initiate EMS pt Care using appropriate SO or call for online medical direction

- No change or decreased patient weight
  
  **Routine CIP Visit**

- Mild increase in weight, dyspnea, edema, or orthopnea from baseline
  
  **Assist the patient in scheduling an appointment with their PCP within 72hrs and schedule a CIP re-check in 24hr**

- New complaint that meets inclusion criteria for any EMS SO that would indicate an EMS intervention is warranted
  
  **EMS Patient**

  - Initiate EMS pt Care using appropriate SO or call for online medical direction

**Special Note:** If a CIP patient is identified as an EMS patient and refuses EMS patient care. That patient should be informed that they will continue to receive CIP services. The CIP provider should call the patients primary care physician to schedule an urgent appointment and schedule a re-check in 24hrs
Community Healthcare Integrated Paramedicine Program (CHIPP)  
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POLICY:  
CHIPP Recent Myocardial Infarction Algorithm

POLICY NUMBER:  
CHIPP 7.2.6

APPROVED BY:  
Josh Gaither, MD Associate Base Hospital Medical Director

Les Caid, Chief

APPROVAL/REVISION DATE(S):  
10/7/2016

OBJECTIVE:  
Provide a decision-making algorithm for CHIPP participants with recent myocardial infarction (MI), particularly for use in deciding if the participant remains stable for a routine CHIPP home visit, or if the participant’s condition is unstable or of increased acuity requiring immediate EMS dispatch.

POLICY:  
CHIPP personnel will apply the recent MI decision-making algorithm to all CHIPP participants who have had a recent MI, and apply it to each scheduled CHIPP visit. Attached is a current copy of the recent MI algorithm provided by the Base Hospital Medical Director.

CHIPP personnel may, at their discretion and using their best clinical judgment, decide to convert a scheduled CHIPP home visit to an immediate EMS response even if the parameters of the decision algorithm are not technically met, if in the clinical judgment of the senior CHIPP care provider present, it would be in the participant’s best interest to do so. In addition, if the CHIPP participant himself requests or insists on an immediate EMS response, then such response will be activated.

See attached “Recent MI Patient Care” decision algorithm.
University of Arizona
Community Integrated Paramedic
Recent MI Patient Care

O2 Sat < 90
SBP <90
RR> 19

EMS Patient
Initiate EMS pt Care
using appropriate SO or call for online medical direction

No CP, dyspnea, or angina equivalent

Routine CIP Visit

Reported stable angina or angina equivalent that responds to prescribed nitrates

CIP Patient
Assist the patient in scheduling an appointment with their PCP within 72hrs and schedule a CIP re-check in 24hr

Reported Unstable Angina, CP or angina equivalent that does not resolve with prescribed nitrates or is different from patients typical angina pain

EMS Patient
Initiate EMS pt Care using appropriate SO or call for online medical direction

Special Note: If a CIP patient is identified as an EMS patient and refuses EMS patient care. That patient should be informed that they will continue to receive CIP services. The CIP provider should call the patients primary care physician to schedule an urgent appointment and schedule a re-check in 24hrs
Section 8: Care Coordination
8.1 Coordinating Care
8.2 Coordinating Care with Other Fire Districts
8.3 Mariposa Clinic Patients Enrolled in CHIPP
8.4 Holy Cross Hospital Patients Enrolled in CHIPP
8.5 Referrals for Follow-up Care (Referrals from CHIPP to Another Agency)
8.6 Using Community Health Resources for CHIPP Participants
8.7 Maintenance of the Community Resources File
Rio Rico Medical and Fire District
Rio Rico, Arizona

Community Healthcare Integrated Paramedicine Program (CHIPP)
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POLICY: Coordinating Care Among Multiple Health Care Providers

POLICY NUMBER: CHIPP 8.1

APPROVED BY: 
Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Coordinating all aspects of a medical care regimen to all involved care providers is important to deliver a high-quality product.

POLICY: Assessments, action plans, progress or setbacks in clinical course, occurrence of side effects, setting prevention and wellness goals and progress toward those goals should all be coordinated and communicated with all involved care providers for CHIPP participants.

Specifically, assessments that reveal new clinical findings should be communicated to the primary care provider, but also to any others directly involved in the provision of on-going care, as, for instance, a home health nurse or aide.

When CHIPP providers develop, with the CHIPP participant, action plans for managing his primary health problem, those action plans should be communicated back to the primary care provider. This may be via the participant taking the action plan to the primary care provider at the next appointment. The action plan should also be known to all other direct care providers. Feedback, with changes or suggestions, from those other providers to CHIPP staff, will result in better-coordinated care.

When positive health behavior changes are planned and accomplished, those also should be routinely communicated to the rest of the care provider team.

Questions, issues, and side-effects from medications should be expeditiously communicated to the on-call CHIPP pharmacist and/or to the Arizona Poison Control Center, or primary care (or prescribing) provider.

Discharge of the participant from the CHIPP program also should be communicated.

Actions taken in communication and coordination of care should be documented in the CHIPP participant record.
Rio Rico Medical and Fire District
Rio Rico, Arizona

Community Healthcare Integrated Paramedicine Program (CHIPP)
Policy Manual

POLICY: Coordinating CHIPP Care with Other Fire Districts

POLICY NUMBER: CHIPP 8.2

APPROVED BY: ________________________________
Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Care of CHIPP participants should be coordinated with other fire districts, when applicable.

POLICY: Coordination of care with other fire districts is indicated for CHIPP participants under certain circumstances. These include at least:

1) An EMS call occurs in the RRMFD and circumstances suggest the possible need of this EMS patient for enrollment in a CHIPP program. The patient reveals that his actual residence is in another nearby fire district that is known to be operating a CHIPP. RRMFD EMS personnel should ask the EMS patient if he would like them to contact the other fire district on his behalf for later possible enrollment in their CHIPP, or leave the EMS patient with contact information about the CHIPP in his home fire district.

2) A RRMFD resident experiences a medical emergency while in another nearby fire district, and EMS is called in that other district. Circumstances are such that the EMS personnel in that other district feel that the patient might benefit from follow-up CHIPP enrollment in the RRMFD. With the patient’s authorization, EMS personnel in the other district are encouraged to contact RRMFD CHIPP personnel with contact information for possible future enrollment into the RRMFD CHIPP.

3) RRMFD CHIPP personnel will be available for informal advice and consultation, as colleagues, to other nearby fire districts as personnel in those districts begin their own CHIPP. In some cases, more formal district-to-district consultation and training may take place.
Community Healthcare Integrated Paramedicine Program (CHIPP)
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POLICY:
Mariposa Clinic Patients Enrolled in CHIPP

POLICY NUMBER:
CHIPP 8.3

APPROVED BY:

Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S):
10/7/2016

OBJECTIVE:
Maintain close communications and coordination with personnel at the Mariposa Community Health Center when a CHIPP participant receives his health care at that Clinic.

POLICY:
Careful attention shall be paid to communication with personnel at the Mariposa Community Health Center (MCHC) regarding a CHIPP participant, when that participant receives his health care at the MCHC. Careful coordination shall take place to ensure that all aspects of the participant’s care is properly coordinated, and that attention is paid to the plan of care developed by the MCHC primary care provider, so that all CHIPP efforts will be complimentary to the MCHC plan of care, and efforts are taken to avoid duplication of services, and that CHIPP and MCHC care plans do not conflict with each other. This includes CHIPP participants who are also being followed by a MCHS promotora doing home visits. Follow the procedures outlined in CHIPP Policy # 3.2, particularly the sections about MCHC patients on pages 4 and 5 of the policy. The initial communications with MCHC about a new CHIPP participant shall take place on the same day as initial enrollment of the new participant. See also CHIPP Policies # 3.1, 8.1, and 8.5.
Community Healthcare Integrated Paramedicine Program (CHIPP)
Policy Manual

POLICY: Holy Cross Hospital Patients Enrolled in CHIPP

POLICY NUMBER: CHIPP 8.4

APPROVED BY: Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Maintain close communications and coordination with personnel at the Carondelet Holy Cross Hospital when a CHIPP participant receives his health care at that hospital (ED, inpatient, or outpatient services).

POLICY: Careful attention shall be paid to communication with designated personnel at the Carondelet Holy Cross Hospital regarding a CHIPP participant, when that participant receives his health care at that hospital/affiliated medical group. Careful coordination shall take place to ensure that all aspects of the participant’s care is properly coordinated, and that attention is paid to the plan of care developed by the Carondelet care provider (such as the ED discharge instructions or the inpatient discharge plan), so that all CHIPP efforts will be complimentary to the Carondelet plan of care, and efforts are taken to avoid duplication of services, and that CHIPP and Holy Cross Hospital care plans do not conflict with each other. Follow the procedures outlined in CHIPP Policy # 3.2 The initial communications with Holy Cross Hospital about a new CHIPP participant shall take place as soon as practicable after initial enrollment of the new participant. See also CHIPP Policies # 3.1 (sections 1-5), 8.1, and 8.5.
Community Healthcare Integrated Paramedicine Program (CHIPP)
Policy Manual

POLICY:
Referrals for Follow-Up Care (Referrals from CHIPP to another agency)

POLICY NUMBER:
CHIPP 8.5

APPROVED BY:

Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S):
10/7/2016

OBJECTIVE:
Services of other health agencies may be useful to a CHIPP participant.

POLICY:
CHIPP personnel should make appropriate referrals for services provided by other health care agencies, and for the participant to take advantage of other useful health services from community organizations, where appropriate and indicated. Such referrals should be made only after discussion with the participant, and with his authorization. If the participant has any difficulty making the connection with the other agency to which he has been referred, direct assistance in contacting that agency may be made by CHIPP personnel. Later, CHIPP personnel should follow up with the participant to see if services provided from that referred-to agency were in fact available and useful.

A list of community health resources will be maintained for reference by CHIPP.

All referral recommendations, actions, and results should be documented in the CHIPP participant’s record.
Rio Rico Medical and Fire District
Rio Rico, Arizona

Community Healthcare Integrated Paramedicine Program (CHIPP)
Policy Manual

POLICY: Using Community Health Resources for CHIPP Participants

POLICY NUMBER: CHIPP 8.6

APPROVED BY: Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: A list of available community health resources will be maintained by CHIPP and will be helpful to the CHIPP participant in helping him with his health care needs, and in taking prevention steps, and in making positive health behavior changes in seeking wellness.

POLICY: CHIPP will maintain a list of available community healthcare resources, with contact information, and a brief description of what sort of services are available at that agency or organization. Examples of types of services that may appear on this list include:

- Stop smoking programs and services
- Information on certain disease types, such as cardiac or respiratory disease, diabetes, or dementia.
- Durable medical equipment
- Disposable medical supplies
- Oxygen tanks, refills, and oxygen generator machines
- Financial assistance for medical services
- Clinics, primary care providers, specialists, and hospitals
- Specialty hospitals
- Mental and behavioral health services
- Exercise gyms and programs
- Meals and nutritional assistance
- Groups of volunteers that may assist with transportation and other services
- Etc.

A current copy of this list of available resources will be carried in the CHIPP medical equipment kit to all home visits and is accessible via: https://drive.google.com/open?id=1NUKc56lDSK457X3QwptOmvHn5pjwB8xmdr201_qL0
Community Healthcare Integrated Paramedicine Program (CHIPP)  
Policy Manual

POLICY:  
Maintenance of the “Community Resources” File

POLICY NUMBER:  
CHIPP 8.7

APPROVED BY:  

Les Caid, Chief  
Joshua Gaither, MD  
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S):  
10/7/2016

OBJECTIVE:  
An accurate and current community resources file is necessary

POLICY:  
All CHIPP personnel are responsible to forward any new information about community medical resources availability to the Lead Community Integrated Paramedic at CHIPP. For instance, when an unsuccessful attempt is made to contact an agency, if the contact information is found to be in error, if the agency no longer provides the listed services, if that agency reveals that another agency (not currently on the list) is available and better suited for the participant’s needs, then updates to the current list must be immediately made to keep it accurate.

The Lead CHIPP paramedic will make such changes, communicate the change to the CHIPP team, and update all copies of the list which originates from the online version found at:  
https://drive.google.com/open?id=1NUKc56lDSK457X3Qwpt0mvHn5pjwBBxcndr201_qL0

All CHIPP personnel will remain alert to the existence of new agencies providing community health resources and see that they are added to the list, when contact information and details are obtained.
Section 9:

Health Promotion

9.1 Health Promotion
9.2 Health Behavior Change Principles
9.3 Motivational Interviewing
9.4 Prevention
9.5 Injury Prevention for CHIPP Participants
9.6 Participant Engagement Toward Self-Care
POLICY: Health Promotion

POLICY NUMBER: CHIPP 9.1

APPROVED BY: Les Caid, Chief
Joshua Gaither, MD

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: A central objective of the CHIPP is health promotion.

POLICY: A central goal of CHIPP Providers in their interactions with the CHIPP Participant is “health promotion.” CHIPP Providers will use multiple techniques to this end. Definitions of “health promotion” include:

**Health Promotion Definition:** Health promotion and disease prevention programs focus on keeping people healthy. Health promotion engages and empowers individuals and communities to engage in healthy behaviors, and make changes that reduce the risk of developing chronic diseases and other morbidities. Defined by the World Health, health promotion is “The process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behavior towards a wide range of social and environmental interventions.”

**Techniques for Health Promotion:** The CHIPP Provider will use multiple techniques to achieve health promotion with the participant, seeking the ones that work best for the individual participant, given his particular health challenges, and the beliefs, realities, and experiences of that participant. These techniques may include:

- Using various approaches outlined in the various health behavior changes theories
- Seeking to enhance client self-efficacy and empowerment
- Use of “Motivational Interviewing”
- General principles of disease and injury prevention

The overall goal is to promote participant engagement toward self-care.

**References:**


POLICY: Health Behavior Change Principles

POLICY NUMBER: CHIPP 9.2

APPROVED BY: Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Outline various theories and principles of health behavior change, and present select approaches useful in the CHIPP setting.

POLICY: CHIPP personnel will consciously select and use various principles of health behavior change to help promote CHIPP participant self-efficacy and engagement toward self-care, prevention, and health improvement.

There are numerous theories of health behavior change. Concepts, principles, and techniques derived from several of these theories may be useful in working with CHIPP participants to help them take control of their own health and related behaviors. Several of these theories are:

- Health Belief Model
- Transtheoretical (Stages of Change) Model of Behavior Change
- Health Action Process Approach
- Theory of Reasoned Action
- Theory of Planned Behavior
- Self-efficacy theory

The CHIPP provider may look into each of the above health behavior change models, which are easily accessed on the internet.

Select concepts, principles, and techniques from several of the models are presented below.

HEALTH BELIEF MODEL:
In the “Health Belief Model” the participant's likelihood of making health behavior changes is predicted by his belief that the health issue is a serious one and that he is, in fact, susceptible to that particular health threat. Various factors then modify the participant’s likelihood of engaging in health-promoting behaviors. These factors include his perception of benefits of and barriers to action, perception of threats that may be involved, his belief that he “can do this,” and the influence of various cues to action that may be present or absent. These concepts are summarized in the diagram below:
Individuals who perceive a health problem as serious, and its potential for real consequences, are more likely to take actions to prevent or minimize the threat of this health problem.

Individuals who believe that they are at risk of a particular health problem, or susceptible to it, are more likely to take actions to avoid or minimize that risk.

The combination of perceived severity and perceived risk is referred to as “perceived threat.” Perceived threat depends on knowledge about the condition. The higher the perceived threat, the more likely positive health behavior changes will be made to avoid or reduce that threat.

If an individual believes that a particular behavior will reduce his threat to a disease, he is more likely to engage in that behavior.

If an individual see barriers to his adoption of a particular health behavior, and those barriers outweigh the perceived threat, then he is unlikely to make that health behavior change. Such barriers may include perceived inconvenience, expense, danger (such as side effects of a medical procedure) and discomfort (such as pain, or emotional upset) involved in engaging in the behavior.

Characteristics of the individual can affect perceptions of seriousness, susceptibility, benefits, and barriers. These characteristics include:
• Demographic variables: age, sex, race, ethnicity, education
• Psychosocial variables: personality, social class, peer pressure
• Structural variables: knowledge about and prior contact with a disease

A cue, trigger, or prompt is necessary for health behavior action to take place.

Self-efficacy refers to an individual’s perception that he is competent to perform a successful behavior change. Basically, this is his belief that, “I can do this.” His confidence in his ability to perform the change affects the likelihood of success.

References for “Health Belief Model”:

**TRANSTHEORETICAL MODEL:**

The transtheoretical model of behavior change, or “stages of change” model, suggests that an individual’s likelihood of action on a health behavior change is a process involving progress through a series of stages:

These stages are:

• **Not ready** (precontemplation): does not intend to take action, and may be unaware that this is a problem
• **Getting ready** (contemplation): recognize behavior is a problem; starts to look at pros and cons
• **Ready** (preparation): intend to take action soon; may start taking small steps toward action
• **Action**: have made behavior changes
• **Maintenance**: are able to sustain new behavior at least 6 months and are working to prevent relapse
• **Relapse**: This specifically applies to individuals with particularly addictive behaviors, who successfully (for example) quit smoking or using drugs or alcohol, only to resume these unhealthy behaviors in the Maintenance stage. Individuals who attempt to quit highly addictive behaviors are at particularly high risk of a relapse.
• **Termination**: have zero temptation and are sure they will not return to old unhealthy behavior
Suggestions for each stage:

- **Not ready**: People here learn more about healthy behavior: they are encouraged to think about the pros of changing their behavior and to feel emotions about the effects of their negative behavior on others. One of the most effective steps that others can help with at this stage is to encourage them to become more mindful of their decision making and more conscious of the multiple benefits of changing an unhealthy behavior.

- **Getting ready**: Ambivalence about changing can cause individuals to keep putting off taking action. People here learn about the kind of person they could be if they changed their behavior and learn more from people who behave in healthy ways. Others can influence and help effectively at this stage by encouraging them to work at reducing the cons of changing their behavior.

- **Ready**: People in this stage progress by being taught techniques for keeping up their commitments such as substituting activities related to the unhealthy behavior with positive ones, rewarding themselves for taking steps toward change, and avoiding people and situations that tempt them to behave in unhealthy ways.

- **Action**: Individuals need to work hard to keep moving ahead. These participants need to learn how to strengthen their commitments to change and to fight urges to slip back. People in this stage progress by being taught techniques for keeping up their commitments such as substituting activities related to the unhealthy behavior with positive ones, rewarding themselves for taking steps toward changing, and avoiding people and situations that tempt them to behave in unhealthy ways.

- **Maintenance**: It is important for people in this stage to be aware of situations that may tempt them to slip back into doing the unhealthy behavior—particularly stressful situations. It is recommended that people in this stage seek support from and talk with people whom they trust, spend time with people who behave in healthy ways, and remember to engage in healthy activities to cope with stress instead of relying on unhealthy behavior.

- **Relapse**: Achieving a long-term behavior change often requires ongoing support from family members, a health coach, a physician, or another motivational source. Supportive literature and other resources can also be helpful to avoid a relapse from happening.

- **Termination**: Little intervention is required, since these individuals have no temptation to relapse.

**References for “Transtheoretical (stages of change) Model”:**


**HEALTH ACTION PROCESS APPROACH:**

HAPA suggests that the adoption, initiation, and maintenance of health behaviors should be conceived of as a structured process including a motivation phase and a volition phase. The former describes the intention formation while the latter refers to planning, and action (initiative, maintenance, recovery). The model emphasizes the particular role of perceived self-efficacy at different stages of health behavior change.

OTHER THEORIES:
Many other theories exist to explain motivation for health behavior change, and how to influence positive behaviors. They include the “Theory of Reasoned Action,” “The Theory of Planned Behavior,” among many others, and multiple theories of “Self-Efficacy.” Further reading and study of these topics is useful.

REFERENCES AND FURTHER READING:
Detailed articles in the medical literature on all of these approaches to influencing health behavior are easily available on the internet. Accurate and simple overviews of these theories are readily accessible on the internet at “Wikipedia,” a source of much of the material presented here (after double-checking accuracy in the longer original journal articles).
POLICY:
Motivational Interviewing

POLICY NUMBER:
CHIPP 9.3

APPROVED BY:
Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S):
10/7/2016

OBJECTIVE:
CHIPP providers will seek to use Motivational Interviewing (MI) techniques while engaging with CHIPP participants as an effective tool to encourage health behavior change.

POLICY:
CHIPP Providers will use MI techniques while interacting with CHIPP participants as an effective tool to promote positive health behavior change. CHIPP Providers are all expected to take an 8-hour MI course as a part of their basic educational preparation for working in the program.

A very brief summary of MI is shown below, as well as links to useful further information on MI.

Motivational Interviewing:
The basic approach to interactions in motivational interviewing is captured by the acronym OARS: (1) Open-ended questions, (2) Affirmations, (3) Reflective listening and (4) Summaries. The acronym is a nice image. It gives us power to move, yet it is not a powerboat. We don’t zip from one place to another, yet with sustained effort OARS can take us a long way.

MI uses four general processes to achieve its ends:

1. Engaging - used to involve the client in talking about issues, concerns and hopes, and to establish a trusting relationship with a counselor.
2. Focusing - used to narrow the conversation to habits or patterns that clients want to change.
3. Evoking - used to elicit client motivation for change by increasing clients’ sense of the importance of change, their confidence about change, and their readiness to change.
4. Planning - used to develop the practical steps clients want to use to implement the changes they desire.
Multiple references and sources for motivational interviewing approaches are available. Several suggested overviews of MI may be found at:

**Motivational Interviewing: Definition, Principles, Approach**  

**Motivational Interviewing Strategies and Techniques: Rationales and Examples**  

**Motivational Interviewing: Resources for Clinicians, Researchers, and Trainers**  

**Motivational Interviewing**  

**Reference:**  
POLICY: Disease Prevention

POLICY NUMBER: CHIPP 9.4

APPROVED BY: ______________________
Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S):

OBJECTIVE: Make prevention of disease occurrence or re-occurrence a priority for all CHIPP participants.

POLICY: Assessing for disease prevention opportunities, reviewing prevention actions taken, setting goals for disease prevention, and encouraging the CHIPP participant toward progress on disease prevention efforts will be a priority at each CHIPP home visit. Prevention-related plans and actions will be documented in the record.

The CHIPP care providers will assess the CHIPP participant for disease prevention opportunities, particularly focusing on the primary health issues the participant faces. The participant’s knowledge about disease prevention will be assessed, and efforts will be made to understand the participant’s current prevention-related health behaviors. Additionally the participant’s motivation to make positive health behavior changes related to prevention will be evaluated.

After the assessment is performed, and while working with that participant and/or health providers in the home, a plan will be developed for making health behavior changes that will positively affect prevention of disease (re-)occurrence. Encouragement and motivational efforts regarding prevention-related behaviors will be made at each visit. Participant responses, and progress toward behavior change will be monitored. Re-assessments will be made over time.

A hypothetical case example of this process may be useful here:

A participant is enrolled in the CHIPP after discharge from a hospitalization due to myocardial infarction. In an early home visit (first or second one), the participant’s knowledge regarding cardiac disease risk factors is assessed. In addition, the CHIPP care provider finds that the participant smokes one pack of tobacco cigarettes a day, is 30 pounds overweight, has hypertension (current BP 146/92), is experiencing significant family and economic stresses, and rarely exercises. His lipid panel shows good results. At the present time three weeks after his MI, he is pain-free, and planning to remain away from work for two more weeks. His understanding of cardiac disease in general, and myocardial infarction and angina specifically, seems weak.
The assessment reveals a need for prevention efforts focusing on:

1) Increase knowledge of cardiac disease and its risk factors.
2) Smoking cessation.
3) Weight reduction.
4) Developing an appropriate exercise regimen.
5) Controlling hypertension.
6) Stress reduction.
7) The participant's willingness and motivation to make positive health behavior changes.

The plan, developed jointly with the participant, to prevent further cardiac disease includes the following.

1) CHIPP provider will teach participant about cardiac disease and its risk factors over next three home visits. In addition, the participant will be given several educational handouts related to cardiac disease. Since the participant is a heavy computer user, several appropriate You Tube videos relating to cardiac risk factors will be identified, and the participant encouraged to watch them, and bring up any questions to the CHIPP provider at the next visit.

2) Participant states he is ready to quit smoking. A referral is made to the ASH-Line, and with their help, he is enrolled in a locally-available stop-smoking program. His primary care provider is informed of this development. Progress is monitored, and success is celebrated at each visit.

3) Based his primary care provider's earlier written recommendation to lose 30 pounds, a plan is developed with the participant to make diet and exercise changes aimed at gradual weight loss. A goal of 5 pounds weight loss is set for the first month, with subsequent weight loss goals to be set each month. CHIPP personnel help participant plan a well-balanced 1,500 calorie/day diet plan. An exercise plan is also developed. Progress is monitored and successes are celebrated at each visit.

4) After consultation with the primary care provider, the participant is enrolled in a cardiac reconditioning program with twice weekly visits planned at a major cardiac hospital in Tucson. The CHIPP team help the participant get enrolled in the program. After the first two visits there, the participant receives a written plan from the cardiac reconditioning team outlining his daily exercise recommendations. The plan calls for walking just 3 blocks a day for the first week, then increasing that to 5 blocks the second week, with further progressive increases in distance walked planned (as tolerated). But the participant expresses fear about going out walking in the neighborhood alone. “What if I have another heart attack?” The CHIPP team decides to walk with him for 3 blocks the first time. This is done without incident, and the participant’s fears are relieved. After one month the participant is able to walk one mile per day with no cardiac symptoms. The CHIPP team monitors the progress and provides encouragement.

5) The participant has a prescription for Losartan 50 mg orally once a day, plus hydrochlorothiazide 25 mg orally once a day to reduce blood pressure. The prescriptions have been filled and the participant has begun taking the medications. The CHIPP team provide answers to his question about the desired effects and the possible side effects of these medications. His blood pressure is taken at each CHIPP visit. The participant is cautioned to drink plenty of fluids and avoid dehydration, since it is in hot weather and he is now taking a diuretic. In combination with his dietary changes, gradual weight loss, successful exercise program, his smoking cessation, and his participation in a stress-reduction program, his blood pressure measurements move into the normal range. This success is celebrated with the participant.

6) CHIPP personnel assist the participant in finding and enrolling in a local Tai Chi program. The goal is stress reduction. The participant also reports that he has begun listening to some audio recordings daily while relaxing on his bed. These audio recordings involve “guided mindfulness meditation” and present soothing music and descriptions of tranquil scenes. The participant states that this really helps him feel calmer, and that he now plans to investigate various on-line “brain training” programs that are supposed to help lower stress. The participant is encouraged.

7) Encouragement, celebration of successes, use of motivation interviewing techniques, and other actions are
taken to promote the participant’s ownership of self-care and positive prevention-related changes in behavior.

8) Periodical re-assessments are performed, and progress is tracked. Findings are documented in the record.

9) Feedback is provided to his primary care provider on the various successful health behavior changes, the improvement and his blood pressure measurements, and the lack of recurrent cardiac symptoms.
POLICY: Injury Prevention for CHIPP Participants

POLICY NUMBER: CHIPP 9.5

APPROVED BY: Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Outline a plan for performing effective injury prevention in the CHIPP.

POLICY: Early in the planned series of home visits for each CHIPP participant, CHIPP personnel will conduct a systematic injury prevention assessment customized for the participant. The assessment will include an evaluation of potential risks for injury in the home and the yard, and during other activities that the participant is involved in such as driving, walking, sports, school, or work. The assessment will include both the environment, and participant behaviors. Once risks have been identified, a written injury prevention plan will be developed. The plan should recognize the middle 3 E’s of intervention in the “5 E’s of Injury Prevention” model (see model below). Those 3 E’s are education, enforcement, and engineering. The participant should be involved in the assessment and developing the prevention plan. The CHIPP personnel should use health promotion, health behavior change, and motivational interviewing techniques to engage the participant toward personal ownership of the injury prevention plan, and to achieve self-care. Periodically re-visit prevention strategies with the participant and provide encouragement for positive behavior change. Document injury prevention actions in the record.

Common home injury risks include: (this is not an exhaustive list)

Medications:
- Accumulated old prescription medications
- Potential for mis-use or overdose of dangerous medications, particularly sedatives and opiates
- Potential for confusion and mix-ups on taking medications properly
- Use of home remedies, botanicals, herbal medicines (yerbas), and cures suggested by a curandera should be carefully assessed for possible toxicity and interactions with other medications (consult pharmacist)

Hazardous materials / Poisoning:
- Evidence of excessive alcohol use
- Chemicals stored improperly
- Potential chlorine hazard around swimming pools or spas
- Poisonous plants in home or on property, if children have access (most serious include Datura, castor-bean plant, Foxglove flowers, and such)
- Lack of carbon monoxide detectors when indicated
**Drowning:**
- Presence of a swimming pool, particularly if small children are present, or use by elderly or weakened persons.
- Lack of proper fencing and gates around swimming pool
- Lack of pool-area rescue equipment
- Lack of proper pool-area supervision
- Spa or hot tub with lack of proper safety cover
- Open water source when small children present (fish pond, bucket, tub, spa, swimming pool, wading pool)
- Boat use by elderly, weak, or unhealthy adult
- Mixing alcohol or drugs with swimming or boating

**Electrical:**
- Lack of ground-fault detector outlets in hazardous areas, particularly near the bathtub, shower, and sinks
- Old, frayed, or cracked appliance wiring
- Overloaded electrical outlets (too many appliances using the same outlet)
- Routine use of extension cords
- Appliance wiring routed under rugs

**Falls:**
- Shaky or unstable ladders present
- Older person or person in poor health using a ladder
- Older male with swamp coolers, tempted to do maintenance on the roof-mounted cooler
- Throw-rugs present (except, perhaps, anti-clip bath mats near tub or shower)
- Cat or dog food dishes on the floor (tripping potential)
- Older person bending over to place pet food dishes on the floor, or retrieve used dishes from the floor
- Guns and ammunition. If present, un-safe storage. Guns separate from ammo, and locked.
- Gun and ammunition access by a depressed person, or a child or teen
- Improperly-stored sharp knives
- Use of workshop machinery by an older or unhealthy person, by someone with poor eyesight
- Lack of walking assist devices when indicated (such as a walker)
- Lack of properly-mounted grab-bars near toilets, baths, and showers
- Possible need for bath / shower modification to permit easier and safer use by elderly or person with reduced strength or mobility
- Excess clutter, including objects such as magazines and newspapers on the floor
- Lack of guardrails and handrails on porches, decks, and stairs
- Presence of steps or stairs for elderly or weak person
- Possible need for physical therapy, or strength / balance training
- Use of sedative, hypnotic, or opiate drugs

**Venomous animals:**
- Snakebite potential increased due to areas open to country-side, vegetation close to walkways, etc.
- Presence of black-widow spider egg casings in areas where hands might be put
- Poor under-door seals allowing entry of scorpions into home
- Possible need for pest control
- Signs that Africanized honeybees are nesting around the home

**Fire / burn:**
- Gasoline or other volatiles stored improperly or near ignition source
- Improper / unsafe barbeque grill use
- Lack of smoke alarms
- Lack of proper fire extinguishers, in date
- Debris store near hot water heater
- Hot water heater temperature setting above 120° F.
• Weeds and vegetation too close to structures
• Excess flammable materials stored
• Window / door iron grills without inside emergency release for escape
• Fireplace / wood stove safety issues

**Sports:**
• Sport with high concussion potential (boxing, football, soccer, etc.)
• Bicycling without helmet and other safety devices
• Walking near traffic; find safer areas to walk
• Presence of trampoline
• Potential for dehydration and hyperthermia due to exercise

**Driving / motor vehicles:**
• All terrain vehicle ATV; quad) use, particularly without helmet, riding double, alcohol, speed, etc.
• No seatbelt use
• Distracted driving, especially texting or cellphone use by driver
• Alcohol use
• Excessive speed
• Following too close
• Elderly drivers
• Poor driver eyesight
• Possible use of car by person with dementia (access to car keys)

**Work or School Environment:**
• Assess for special injury risk in particular work or school situations

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**The “5 E’s” of Injury Prevention Model:**

- **EPIEDEMILOGY**
  who, what, when, where? extent of the injury problem
- **EDUCATION**
  information, knowledge, preaching
- **ENFORCEMENT**
  laws, regulations, rules of behavior, expectations, societal norms
- **ENGINEERING**
  physical environment
- **EVALUATION**

Injury Prevention Process.
**General injury prevention strategies:**

EDUCATION. This includes providing information and educational materials, sharing knowledge, formal teaching, “preaching,” encouragement, motivating, empowering toward self-care, and similar approaches. The education approach is likely the easiest prevention strategy, and also likely the least effective, since it relies on individual behavior change.

ENFORCEMENT. This strategy includes formal law enforcement, but also other “enforcement” strategies such as regulations within groups / schools / workplaces; setting behavior goals and expectations, implementing negative consequences for behavior violations, and use of peer pressure / social expectations to encourage safe behavior.

ENGINEERING. This strategy is often the most difficult to implement, but at the same time often the most effective. These strategies include environmental modifications to improve safety, such as installing a sloping ramp to replace stairs for a person with mobility limitations, fencing around a swimming pool, installing safety grab bars in the bathroom, purchasing a car with improved safety features such as automatic breaking to prevent a crash, and such. In the home setting, some environmental modifications to reduce injury potential may be simple and not difficult to accomplish, such as removing throw rugs and pet dishes from the floor, or sealing up a crack on the house exterior to prevent Africanized bees from nesting there.
COMMUNITY HEALTHCARE INTEGRATED PARAMEDICINE PROGRAM (CHIPP)

POLICY MANUAL

POLICY: Participant Engagement Toward Self-Care

POLICY NUMBER: CHIPP 9.6

APPROVED BY: Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Multiple strategies will be explored with each CHIPP participant to discover what works to make progress toward participant engagement in self-care. The goal is for the participant to own responsibility for his on-going health care needs, and recognize the usefulness of making positive health behavior changes to improve his health status.

POLICY: CHIPP personnel will focus on finding successful strategies, at every CHIPP home visit, to help the participant own responsibility for his own health issues, and embrace opportunities to change his health behaviors to promote prevention and improved health.

In this regard, CHIPP personnel will consciously seek the best strategies to reach this goal, during all home visits. CHIPP personnel will recall the various techniques and principles of health behavior change theory, health promotion, motivational interviewing, disease prevention strategies, and various other techniques to may engage the participant toward self-care.

Initially, CHIPP personnel will make efforts to be supportive, so that the participant does not feel overwhelmed with his health issues and that he feels that he “is not in this alone.” As assessments are made, action plans developed, the participant challenged and engaged in making health behavior changes, and successes realized, the CHIPP personnel will make every effort to commend the progress, point out the successes, encourage continued efforts, and celebrate successes. This likely will provide and enhanced sense of empowerment for the participant, paving the way for additional progress. The participant’s sense of self-control and self-worth will likely be improved.

Along the way, the CHIPP personnel will gradually step back and allow the participant to take more control over his health future. And as this occurs, gradually point this out, underscoring that it is the participant himself who is in charge, who can made the progress, and who is now truly engaged in self-care.

Progress on this pathway, when successful, naturally leads to planning to end the need for continued CHIPP team involvement, and eventually the participant’s graduation and discharge from the CHIPP.
The CHIPP personnel will record the assessments, the conscious plan to reach health improvement and self-sufficiency goals, the strategies that are identified that work with this particular participant (and those that do not), the actions taken, the successes achieved, and the participant’s expressed reactions to this progress.
Section 10:
Quality, Satisfaction, Outcomes

10.1 General Plan for CHIPP Quality Improvement
10.2 Systematic Care Review
10.3 Programmatic Problem Solving
10.4 Participant Satisfaction
10.5 Evaluation of CHIPP Outcomes
10.6 Loop Closure
Community Healthcare Integrated Paramedicine Program (CHIPP)  
Policy Manual

POLICY: General Plan for CHIPP Quality Improvement

POLICY NUMBER: CHIPP 10.1

APPROVED BY:
Josh Gaither, MD Associate Base Hospital Medical Director
Les Caid, Chief

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Opportunities to improve the quality of the CHIPP will be active sought on a continuous basis, and this process will be facilitated by a formal quality improvement program.

POLICY: The CHIPP will maintain a strong program of quality improvement. All CHIPP providers will remain alert for opportunities to improve quality, and will communicate these ideas to the lead Community Integrated Paramedic and/or the CHIPP Director, and add the ideas to the agenda of the CHIPP Team meeting for further discussion and/or action.

The formal quality improvement program will consist of five main sections:

Systematic care review.
1) A list of positive quality indicators will be developed. In addition, a list of quality red-flag indicators will be developed. Each of these lists of quality indicators may be changed from time to time, as the program evolves. A formal structure will be developed to review for the presence of the positive quality indicators, and for the quality red-flag indicators on a structured time-table. When positive or negative quality indicators are found, further investigation may reveal opportunities for improvement. Such opportunities will be added to the active programmatic problem-solving list.

2) A defined sample of medical records of CHIPP home visits will be systematically reviewed using a quality indicator checklist to search for both positive and negative quality indicators. When such indicators are found, further investigation may reveal opportunities for improvement. Such opportunities will be added to the active programmatic problem-solving list.

Participant satisfaction. Using a written or telephone questionnaire, questions will be developed to be administered to all discharged CHIPP participants (or main in-home care provider) regarding their satisfaction with the CHIPP. Results...
will be analyzed regularly, and findings included as input into the overall CHIPP quality improvement program. Some results may suggest the need for programmatic problem solving, and will be added to the active problem list.

**Evaluation of CHIPP outcomes.** A list of desirable program outcomes will be developed. These health and financial outcomes are of CHIPP participants as a group, such as indicators of reduced occurrence of medical complications, reduced need for 911 calls, and reduced re-hospitalizations, with financial outcomes such as reduced medical and EMS expenditures. These outcomes, over time, will also be used to determine CHIPP quality.

**Programmatic problem solving.**
Quality problems or issues identified by an individual CHIPP EMT or paramedic, by the systematic care review, from participation satisfaction results, or by evaluation of overall program outcomes will be maintained on an active programmatic problem-solving list. The lead community integrated paramedic and the CHIPP Director will collaborate regularly to review the list of problems to be solved, develop sound and feasible strategies to solve the problems, and maintain records of all such quality improvement activity.

**Quality Improvement Loop Closure.**
Once strategies have been selected and implemented to solve identified quality problems, follow-up study and evaluation will be required to determine if such strategies have been effective in actually improving the quality problem. Demonstrating effective problem solution via strategy implementation is termed “closing the loop” on quality improvement. Closing the loop, that is, actually solving the problem (eliminating or substantially reducing it) is the bottom line for the quality improvement program.

Ultimate responsibility for the success of the CHIPP quality improvement program rests with the CHIPP Director and the Chief, but they will be actively assisted in carrying out the quality improvement program by the Lead Community Integrated Paramedic. In addition, all CHIPP providers bear some responsibility for identifying quality issues, and helping to find and implement improvements.
 community healthcare integrated paramedicine program (cHIPP)  
Policy Manual

policy:  systematic care review

Policy number:  cHIPP 10.2

Approved by:  

Josh Gaither, MD Associate Base Hospital Medical Director

Les Caid, Chief

Approval/revision date(s):  10/7/2016

Objective:  A systematic search for quality problems or opportunities for improvement by reviewing the medical records from a select sample of cHIPP home visits on a regular basis will result in improvements in overall program quality.

Policy:  A program of systematic care review will be implemented in the cHIPP program. This medical record review process will be performed regularly on a defined sample of home visits using a standard checklist of quality indicators. Quality problems or opportunities for quality improvement identified in this process will be identified. Issues so identified will be reviewed, searching for strategies to make positive changes.

1) A list of positive quality indicators will be developed. In addition, a list of quality red-flag indicators will be developed. Each of these lists of quality indicators may be changed from time to time, as the program evolves. The defined indicators will be included in a care review checklist.

2) Using the current indicator checklist, a sample of cHIPP home visit medical records will be compared with the indicators on the checklist. For example, one indicator could be: “The medical record indicates that at each home visit, the cHIPP team has documented that participant prevention / health behavior change goals were assessed and discussed with the participant, and the participant was encouraged to continue to work on those goals.” Using this indicator, records lacking this information will be tallied and compared with the total number of records reviewed. A rate of failure to meet this care objective will be so developed.

3) A target rate will be established for each indicator on the checklist. For example, using the hypothetical indicator in #2 above, the target might be set at 90% compliance. If less than 90% of the records meet the indicator, then an opportunity for improvement exits, with a goal to move performance into the zone above 90%. If monitoring over time
reveals the results are consistently over 90%, then this indicator might eventually be abandoned, and other quality indicators developed. A manageable number of total checklist indicators should be in play at any given time, perhaps four or five, certainly less than 10.

4) When a checklist indicator shows consistent performance below the target level, the problem should be moved to the active problem-solving list. This list, in constant use, will contain current problems identified for improvement efforts, as well as other opportunities for program improvement.

5) As strategies are identified and implemented, the assessment of the particular checklist indicator will continue, looking for evidence that improvements are being made, and target quality goals are being met.

6) Persons doing the medical record review are as assigned, and may include the CHIPP Director, the Lead Community Integrated Paramedic, or CHIPP EMT’s or paramedics (doing “peer review”) – they do not review their own charts, but those of their peers. Efforts will be taken to insure that records of all CHIPP providers are included in the process.

EXAMPLE (hypothetical) CHIPP Quality Indicator Checklist for Use in Systematic Care Review, with Yearly Results:

<table>
<thead>
<tr>
<th>#</th>
<th>Indicator</th>
<th>Target*</th>
<th>Qtr 1</th>
<th>Qtr 2</th>
<th>Qtr 3</th>
<th>Qtr 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Prevention/health behavior goals review and discussed at each home visit, and participant encouraged to continue working toward goals.</td>
<td>90%</td>
<td>14/32</td>
<td>19/28</td>
<td>21/26</td>
<td>23/25</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>44%</td>
<td>68%</td>
<td>81%</td>
<td>92%</td>
</tr>
<tr>
<td>2</td>
<td>BP, pulse rate, respiratory rate recorded at each home visit.</td>
<td>95%</td>
<td>31/32</td>
<td>26/28</td>
<td>26/26</td>
<td>24/25</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>97%</td>
<td>93%</td>
<td>100%</td>
<td>96%</td>
</tr>
<tr>
<td>3</td>
<td>O₂Sat recorded at each home visit if problem is cardiac or respiratory.</td>
<td>95%</td>
<td>5/5</td>
<td>6/7</td>
<td>7/7</td>
<td>6/6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>100%</td>
<td>86%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>4</td>
<td>Medications reviewed with patient at each home visit.</td>
<td>90%</td>
<td>23/32</td>
<td>17/28</td>
<td>17/26</td>
<td>19/25</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>72%</td>
<td>61%</td>
<td>65%</td>
<td>76%</td>
</tr>
<tr>
<td>5</td>
<td>Scheduled missed because of RRMFD CHIPP personnel issue, or scheduled visit re-scheduled to later because of CHIPP personnel.</td>
<td>&lt; 4%</td>
<td>0/32</td>
<td>1/28</td>
<td>0/26</td>
<td>0/25</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0%</td>
<td>3.6%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

*Percent of charts reviewed that achieved the indicator. Indicators and targets might be framed in a negative or positive manner.

In above example, indicator #1 showed very poor performance in the first quarter, with improvement over the next three quarters, but last quarter showing results just above the target of 90%. Therefore, the monitoring with this quality indicator will continue into the next year. Assessment is that strategies implemented at the beginning of quarter 2 are showing continuous improvement, and will be continued into the next year until consistent results > 90% are achieved.

Indicator #2 data show that there is no quality problem with this indicator, and the indicator will be dropped for the next year, and replaced with another indicator.

Indicator #3 shows that over the entire year of data monitoring, there was only one time when the indicator goal was not met, so there is no evidence that a quality issue exists. The indicator will be dropped and replaced with another one for the next year.

Indicator #4 data show that a quality problem exists, and that improvement strategies that were begun at the beginning of the second quarter have failed to produce improvement. Therefore, the indicator will be monitored into the second year, with new improvement strategies identified and implemented as a priority for year #2.
Indicator #5 data show, like indicator #3, only one instance where the indicator was triggered, but even then results fell within the target zone. No quality problem exists with this indicator, which will be dropped in year 2 in favor of a different indicator.
POLICY: Participant Satisfaction

POLICY NUMBER: CHIPP 10.3

APPROVED BY: Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Provide services to CHIPP participant that satisfies their needs.

POLICY: Develop and implement an on-going participant satisfaction survey to be administered to all CHIPP participants shortly after their discharge. Analyze survey results on a regular basis, and forward opportunities for improvement to the current problem-solving list for action.

A written or telephone questionnaire regarding CHIPP participant satisfaction will be developed, implemented on an on-going basis, and revised as indicated from time to time. Results of these surveys will be regularly analyzed, seeking opportunities for improvement. Such opportunities, once identified, will be forwarded to the current problem-solving list for action.

If a CHIPP participant is unable to complete the survey due to medical or mental issues, then that participant’s in-home care provider or appropriate surrogate may complete the questionnaire on his behalf.
POLICY: Evaluation of CHIPP Outcomes

POLICY NUMBER: CHIPP 10.4

APPROVED BY: Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S): 10/7/2016

OBJECTIVE: Improvement in health status with lowered costs is a central objective of the CHIPP program.

POLICY: As an essential part of the CHIPP quality improvement program, outcomes of the CHIPP program will be evaluated on an on-going basis. By “outcomes” is meant the ultimate, final results or effects of the CHIPP program. The objective is to see CHIPP participants with improved health, with less use of resources, and at lowered costs.

“Improved health” can be measured in a number of ways. For example, fewer sick days away from school or work, fewer episodes or flare-ups of the underlying medical condition (such as fewer asthma attacks, less use of asthma inhaler medication, fewer episodes of chest pain or use of nitroglycerine for angina, etc.), fewer 911 calls for EMS, fewer visits to the emergency department (ED), fewer re-hospitalization episodes, reduced number of intensive-care-unit days, and a lower total number of hospitalization days. Some of these, or similar, measures will be selected to measure health improvement over a longer period of time (perhaps several years).

“Reduced resource use” and “lower cost” can also be measured in a number of ways, such as fewer 911 calls, reduced number of participants who re-enroll in the CHIPP program, less cost for EMS response and ambulance service, less cost for ED visits, lower hospitalization cost, etc. Some of these, or similar, measures will be selected to measure reduced resource use or lower cost over a longer period of time (perhaps several years).
POLICY:
Programmatic Problem Solving

POLICY NUMBER:
CHIPP 10.5

APPROVED BY:
Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S):
10/7/2016

OBJECTIVE:
Identification of quality problems or opportunities for improvement has little meaning unless such problems are actually solved, or the improvement is actually made. The objective is to solve problems and make quality improvements.

POLICY:
An active, on-going list of problems to be solved, and quality improvements to be made will be maintained for the CHIPP. The list should be revolving, that is, new items are added, and other items are removed as problems are actually solved or improvements actually made. Removing items from this quality “to-do” list is a central measure of success for the CHIPP program.

The Lead Community Integrated Paramedic will maintain the list, and be responsible for implementing strategies to removed items from the list as a consequence of that problem being solved, or that opportunity for improvement being made. The Lead Paramedic will regularly discuss the active list with the CHIPP Director. Items that remain on the list for longer periods of time than usual may be targeted for priority action. Ultimately, it is the responsibility of the CHIPP Director and the Chief to insure that this programmatic problem-solving list is used successfully to increase the overall quality of the CHIPP.

A record will be kept of all items added to the list, and all items removed from the list, the dates of additions or deletions, the reasons for all additions or deletions (data that indicate the need for addition or removal), and the dates when progress with use of the list are discussed/reviewed/evaluated. This record can be used to see overall progress for quality improvement in the CHIPP.
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POLICY:
Loop Closure in CHIPP Quality Improvement

POLICY NUMBER:
CHIPP 10.6

APPROVED BY:
Les Caid, Chief
Joshua Gaither, MD
Associate Base Hospital Medical Director

APPROVAL/REVISION DATE(S):
10/7/2016

OBJECTIVE:
Identified quality problems should be solved in order to effect quality improvement.

POLICY:
A bottom-line focus in conducting the CHIPP quality improvement program will be solving identified problems. Demonstrating that problems are effectively solved with a resulting improvement in quality is the essence of the QI program.

Step 1: Problems or negative performance issues must first be identified by CHIPP provider input or systematic searches for quality issues. In addition, other opportunities for improving program quality will be identified, often as a result of program growth, maturity, increased resource availability, or changing conditions and community health-care needs.

Step 2: Once an opportunity for improvement is identified, analysis and planning will lead to identification of various strategies to make that improvement. The most promising strategies will be selected for implementation.

Step 3: Improvement strategies will be implemented.

Step 4: Baseline data from quality indicators will be compared with on-going data collection during and after improvement strategy implementation. The data will be analyzed.

Step 5: Loop closure is achieved when on-going data indicate that the implemented strategies have actually resolved the problem (eliminating or substantially reducing it) or resulted in program quality improvement.
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