MEMORANDUM OF UNDERSTANDING

This Memorandum of Understanding ("MOU"), effective as of the last signature below, is entered into between Presence Central And Suburban Hospitals Network, d/b/a Ascension Saint Joseph Medical Center ("Ascension") and the City of Joliet.

SCOPE OF SERVICES

The City of Joliet Health & Human Service divisions are operated under the auspices of the Joliet Fire Department (JFD). JFD's Community Paramedicine Program ("CPP") seeks to connect residents experiencing a high risk of medical health, mental health, substance use, and general anxiety readmissions to healthcare services. Additionally, the CPP helps citizens with basic needs and homelessness which effects operations at the hospital and supports programs within and around the Community.

It is the policy and practice of the City of Joliet to continually partner with other providers in the community to maximize service delivery to our residents. We hope to add additional structure to our collaboration through the development of basic procedures that hopefully will make service coordination more efficient and effective. The policies and procedures for the CPP are outlined in the Joliet Fire Department Community Paramedicine Program Development and Implementation Guide attached as Exhibit A.

COMPLIANCE

Compliance with Laws. JFD represents and warrants that all services provided comply with all applicable federal, state and local laws, ordinances, regulations and codes. JFD represents and warrants that it is not a Business Associate as defined by HIPAA and that in the provision of services, JFD does not require and shall not request or attempt access to any Protected Health Information of Ascension.

Excluded Provider. JFD represents and warrants that neither it, nor any of its employees or other contracted staff has been or is about to be excluded from participation in any Federal Health Care Program (as defined herein). The listing of JFD or any of its employees on the Office of Inspector General's exclusion list (OIG website), the General Services Administration's Lists of Parties Excluded from Federal Procurement and Nonprocurement Programs (GSA website) for excluded individuals or entities, any state Medicaid exclusion list, or the Office of Foreign Assets Control's blocked list shall constitute "exclusion" for purposes of this paragraph. For the purpose of this paragraph, the term "Federal Health Care Program" means the Medicare program, the Medicaid program, TRICARE, any health care program of the Department of Veterans Affairs, the Maternal and Child Health Services Block Grant program, any state social services block grant program, any state children's health insurance program, or any similar program.

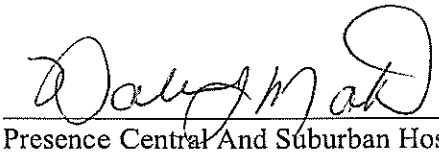
EEOC. The parties shall abide by the requirements of 41 C.F.R. 60-1.4(a), 60-300.5(a) and 60-741.5(a), and the posting requirements of 29 C.F.R. Part 471, appendix A to subpart A, if applicable. These regulations prohibit discrimination against qualified individuals based on their status as protected veterans or individuals with disabilities and prohibit discrimination against all individuals based on their race, color, religion, sex, sexual orientation, gender identity or national origin. Moreover, these regulations require that covered prime contractors and subcontractors take affirmative action to employ and advance in employment individuals without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, disability, or veteran status.

Corporate Responsibility Program. Ascension has in place a Corporate Responsibility Program which has as its goal to ensure that Ascension complies with federal, state and local laws and regulations. The Program focuses on risk management, the promotion of good corporate citizenship, including the commitment to uphold a high standard of ethical and legal business practices, and the prevention of misconduct. JFD acknowledges Ascension's commitment to Corporate Responsibility and agrees that it will not act or conduct business in a manner that requires Ascension to violate or act in a manner that contravenes the Program.

Ethical and Religious Directives. The parties acknowledge that the operations of Ascension and its affiliates are in accordance with the Ethical and Religious Directives for Catholic Health Care Services, as promulgated by the United States Conference of Catholic Bishops, Washington, D.C., of the Roman Catholic Church or its successor ("Directives") and the principles and beliefs of the Roman Catholic Church are a matter of conscience to Ascension and its affiliates. The Directives are located at https://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf. It is the intent and agreement of the parties that neither this MOU nor any part hereof shall be construed to require Ascension or its affiliates to violate said Directives in their operations and all parts of this MOU must be interpreted in a manner that is consistent with said Directives.

_____ Date: _____

Joliet Fire Department, Deputy Chief Health Services



Date: 6/17/2024

Presence Central And Suburban Hospitals Network
d/b/a Ascension Saint Joseph Medical Center,
Division Director

Exhibit A

Joliet Fire Department
Community Paramedicine Program
Development & Implementation Guide

Phase 1: V1.4, 2023

Table of Contents

Section 1: Executive Summary

Community Paramedicine Description and Goal (See attached Program Manual)

The Community Paramedicine Program (CPP) is a new initiative developed within the Joliet Fire Department (JFD). The primary goal of the CPP is to begin to bridge the gap between the community and mental and general healthcare services by educating the public regarding healthy behaviors, providing resources, establishing prevention programs, providing effective crisis care, improving outreach, and establishing relationships with professionals providing needed levels of care. This program is written to be linguistically and culturally competent, will reduce readmissions to local hospitals after discharge, and will improve patient outcomes.

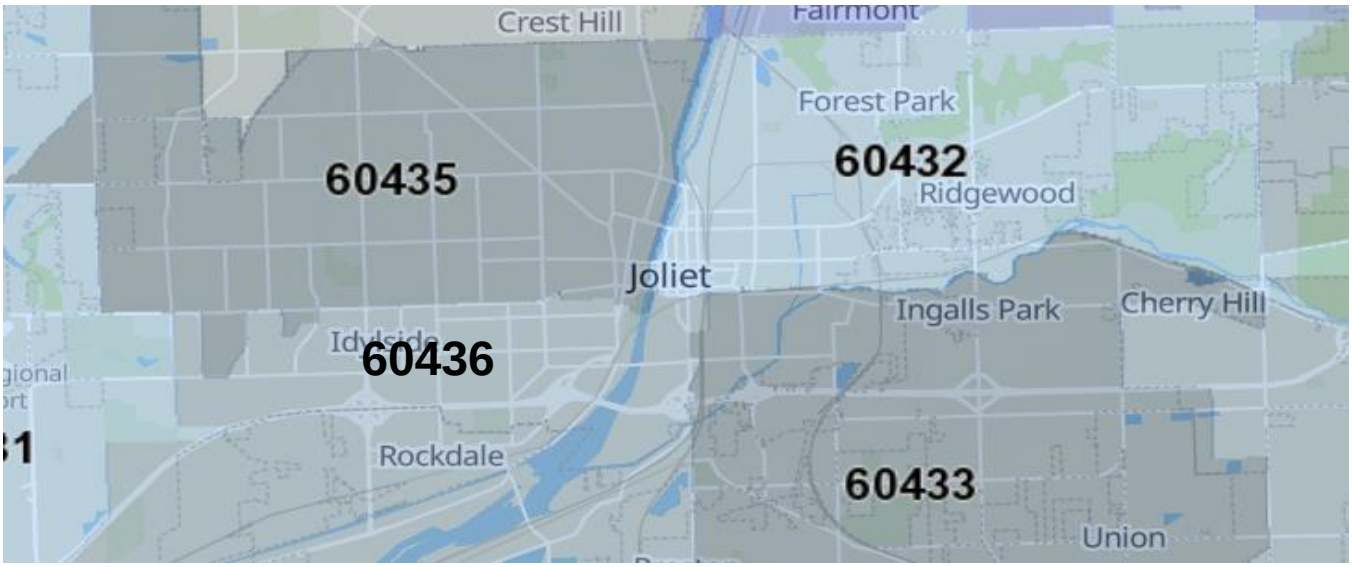
The JFD Deputy Chief of Health Services will manage the CPP, and input will be provided by the Deputy Chief of Human Services. It will initially be staffed by one grant-funded, full-time Community Paramedic (CP) and be supported by a 12-member CP special team within the JFD. The Community Paramedicine Team (CPT) will be like other existing JFD special teams (Hazardous Materials Response, Fire Investigation, Dive/Rescue Team, and Honor Guard) in that members will participate in training and special projects. The EMS Battalion Chief will assign these assignments.

CPP Qualified Census Tracts and Zip Codes

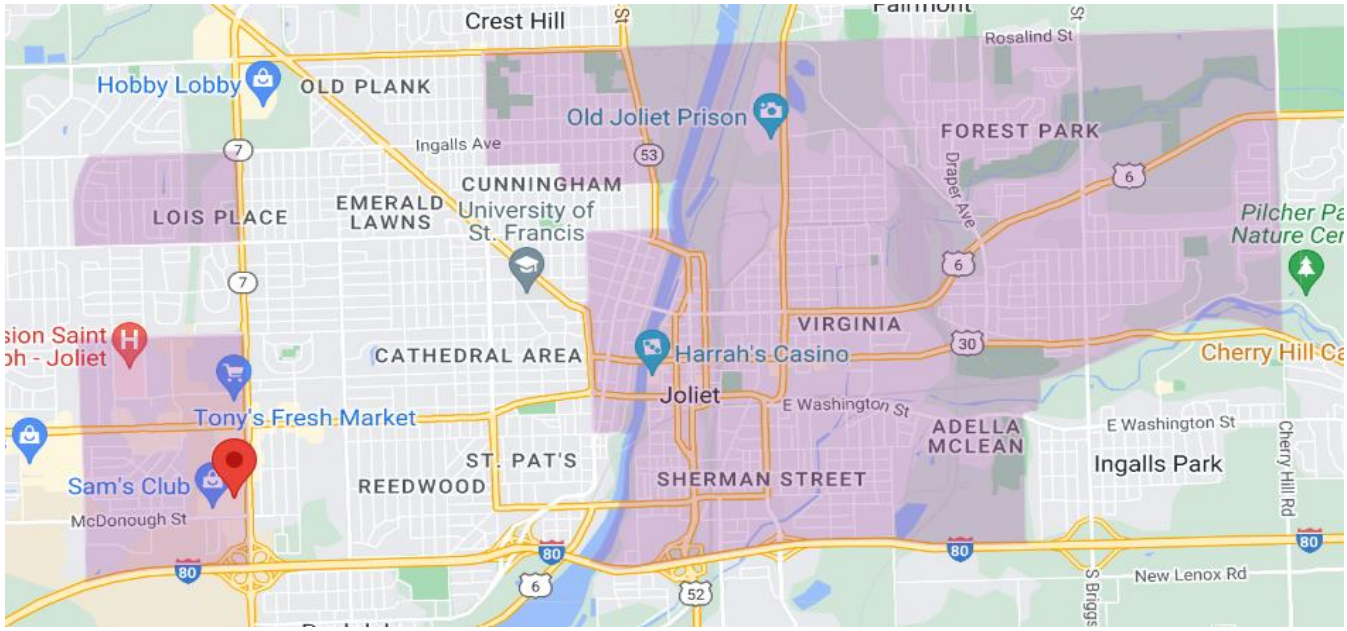
The Joliet Community Paramedic (CP) will be a critical component of the healthcare system, especially for disadvantaged residents who may experience low income, lack suitable access to primary mental health and physical care, and experience transportation issues. The Will

County area of the City of Joliet is home to numerous Qualified Census Tracts, as defined by the Office of Policy Development and Research (PD&R), containing over 30,000 Will County residents. The Zip Codes within these Census Tracts will be used to manage and track patients and outcomes. The focus of this program will be Zip Codes 60432, 60433, 60435, and 60436.

Zip Codes



Qualified Census Tracts



The specific Qualified Census Tracts are:

- Tract 8812.01: Population 2,095
- Tract 8812.02: Population 2,460
- Tract 8813.01: Population 3,040
- Tract 8813.02: Population 1,307
- Tract 8814.01: Population 3,418
- Tract 8816.03: Population 3,301
- Tract 8819: Population 3,725
- Tract 8820: Population 3,445
- Tract 8821: Population 2,596
- Tract 8822: Population 3,934
- Tract 8824: Population 3,392
- Tract 8825: Population 2,246
- Tract 8828.02: Population 3,018

Cultural and Linguistic Competency

The City of Joliet is a diverse community. For this reason, the CPP must perform services in a structurally, culturally, and linguistically competent way, using the *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care* to provide effective, equitable, understandable, and respectful care. This provision includes cost-free verbal and written interpretation services (by video remote translation or other means), non-use of minors or untrained individuals, and translated materials that align with the patient's communication needs.

The CP and CPT members will complete *Culturally Competent Nursing Care: A Cornerstone of Caring* through The U.S. Department of Health and Human Services (HHS) Office of Minority Health (OMH) to ensure they have the tools to communicate effectively with their patients. The principles of this program apply to paramedics and nurses.

CPP Goals

The CPP will perform several tasks, including post-hospital follow-up, outreach, and home visits to help those in the identified Zip Codes manage acute and chronic conditions. Post-

admission follow-up will be offered to patients released from the two area hospitals (St. Joseph Medical Center (Behavioral) and Silver Cross Hospital (Medical) in the identified Zip Codes.

The CPP will also provide outreach programs to focus on prevention and instill healthy behavior habits in residents. This outreach may include neighborhood canvasses, immunization delivery, diet and exercise information dissemination, or other needs identified by the EMS and CRR Battalion Chiefs. Also, the CPP will provide the residents with medical and mental health resources and referrals to needed levels of care, some of which already exist in the community but remain untapped.

The CP's abilities to visit the patient in their home and perform outreach in the community are critical to the program's success. Home assessments reduce the patient's transportation needs while allowing in-person physical examination and evaluation, permitting the CP to observe the conditions where the patient resides, noting risks and potential improvements within the lived environment. Outreach allows the CPP to go into the community and offer services to patients who may otherwise not seek care for acute illness or chronic disease management.

CPP Objectives

Year One

- Perform community assessment (Strategic).
- Assign one new full-time employee to the Emergency Medical Services (EMS) Division of the JFD. This paramedic will work with administrators already in place within the JFD Divisions of Health and Human Services, become the liaison with Silver Cross Hospital, and perform CP tasks for those discharged from that facility. The Health and Human

Chief Administrators will implement the program based on community assessment (Strategic).

  - Measurement: Filled position.
  - Measurement: Program documents.

- Train and certify the full-time employee to the Board-Certified Community Paramedic (CP-C) level through the International Board of Specialty Certification (IBSC) (10-week course and exam) and *Culturally Competent Nursing Care: A Cornerstone of Caring* through The U.S. Department of Health and Human Services Office of Minority Health (OMH) (e-learning, 9-hours) (Tactical).
  - Measurement: Certification documents.
- Discuss, plan, and implement a Medical Direction strategy for the program. Secure a Medical Director physician to help manage the program through area hospitals (Operational). The current plan for accomplishing this task is to use a physician from the Behavioral Unit at St. Joeseph Medical Center and a physician from the Emergency Department (ED) at Silver Cross Hospital to manage respective follow-ups.
- Select, train, and certify the members of the CPT to the Board-Certified Community Paramedic (CP-C) level through the International Board of Specialty Certification (IBSC) (10-week course and exam) and *Culturally Competent Nursing Care: A Cornerstone of Caring* through The U.S. Department of Health and Human Services Office of Minority Health (OMH) (e-learning, 9 hours) (Tactical).
  - Measurement: Certification documents.
  - Measurement: Team roster.

- Acquire needed equipment and define the roles and responsibilities of the program providers (Tactical).
    - Measurement: Policy Documents
        - Measurement: Medical Plan
        - Measurement: Behavioral Plan
- Establish short- and long-term performance metrics to assess the program's effectiveness (Strategic).
    - Measurement: Metric development.
- Perform individual Zip Code evaluations, focusing on health and behavioral issues determined by data mining EMS reports (Operational).
    - Measurement: Census Tract/Zip Code documents and evaluation forms.
- Perform an initial annual assessment of the program using established performance metrics (Tactical).
    - Measurement: Annual Report.

Year Two

- Fully implement the program (Operational).
    - Physical Health
        - Offer/perform follow-up for discharged medical patients from Silver Cross Hospital & Ascension St Joseph Medical Center into the identified Zip Codes in five primary areas of medical need: Heart failure, post-myocardial infarction, orthopedic (knee and hip), diabetes, and pneumonia. Additionally, follow-up will also include a sixth area which will be behavioral health.

- Create handouts, online videos, and in-person courses, and develop other methods to encourage healthy behaviors, chronic disease, and medication compliance in the community. Critical aspects of the CPP include educating patients on health behaviors in both mental and physical areas, helping patients secure primary care providers, and helping them manage chronic disease (Tactical).
    - Measurement: Assessment and patient care documentation.
    - Measurement: Physical creation of handouts, online videos, and in-person course evaluations from students.
- Develop/implement a CP outreach program for general health screenings such as blood pressure, blood sugar, fall prevention, and other assessments for those with limited transportation or inadequate access to care. This program will be offered to all identified Zip Codes (Strategic) residents.
    - Measurement: Policy and procedure manuals.
    - Measurement: Scheduled health events.
- Revise and maintain a comprehensive physical and mental health resource list (Tactical). Many individual resources exist for psychological and physical health within Joliet and Will County. While some of these resources are known and used, many do not know about each other's existence and work in individual silos without coordination among agencies.
    - Measurement: Updated Resource Guide.
- Perform an annual program review using performance metrics (Tactical).
    - Measurement: Annual Report.

All Years

- Provide referrals for mental and physical healthcare resources outside the CPP (Operational).
    - Measurement: Documented referrals.
    - Measurement: Completed physician agreement forms.
- Partner with local agencies to increase cultural and linguistic awareness and proficiency.
    - Measurement: Partner list.

CPP Planned Phases

Phase 1: 2023-2026

Grant period: Silver Cross Hospital, Qualified Census Tracts/Zip Codes.

Grant period: St. Joseph Medical Center, Qualified Census Tracts/Zip Codes.

Phase 2: 2027

More extensive implementation: Expand Census Tracts/Zip Codes outside Qualified Census Tracts into other areas.

Phase 3: 2028

Citywide expansion.

Section 2: Mission, Vision, and Values

Mission Statement

It is the Mission of the Joliet Fire Department Community Paramedicine Program to support increased access to medical and mental healthcare by providing equitable, knowledge-based, and compassionate care to our citizens.

Vision Statement

A Joliet Community that provides exceptional healthcare management opportunities to all citizens.

Values

Community: One City

Equity: Equal access to quality healthcare

Knowledge: Community Education and Information

Compassion: Caring and empathetic patient service

Section 3: Community Paramedicine Defined

Introduction

Community Paramedicine (CP) is a growing medical service field that seeks to fill critical behavioral and general health gaps between the community and primary and definitive care. The Community Paramedicine Program (CPP) will work under the Emergency Medical Services (EMS) with input from the Community Risk Reduction (CRR) Divisions within the Joliet Fire Department (JFD). A CPP will profoundly affect Joliet's behavioral and general health outcomes.

Joliet Fire Department

The JFD serves over 150,000 residents and responds to over 22,000 service calls annually. The 200 firefighters of the JFD provide community fire suppression, emergency medical care, crisis intervention, outreach, education, active intervention, innovative prevention, and professional response to community needs. The CPP will inform patients with acute and chronic conditions on managing their issues and avoid needing emergency transport or readmission to medical facilities.

Community Paramedic Programs (CPP)

According to the Rural Health Information Hub, Community Paramedicine Programs (CPP) have two potential goals: increasing access to primary care and reducing emergency medical service (EMS) use. Additionally, CPPs may take two forms: expanded scope and expanded role. Expanded scope models are models in which the CP receives specialized training to extend their scope of practice. The expanded role, in contrast, includes the CP acting in their current scope of practice in non-traditional roles using already possessed skills.

The Joliet Fire Department Community Paramedicine Program is an **Expanded Role Program**.
It allows JFD Paramedics to operate as Community Paramedics within their current scope of practice with additional education geared toward community health (see Section 6 for training requirements).

CPPs have proven their ability to reduce readmissions for patients experiencing several illnesses. They may be helpful for patients experiencing common readmission illnesses, such as heart failure, diabetes, and pneumonia.

The CPP will perform several tasks, including post-hospital follow-up, outreach, and home visits to help those in the identified Zip Codes manage acute and chronic conditions. Post-admission follow-up will be offered to patients released from the two area hospitals (St. Joseph Medical Center and Silver Cross Hospital) in the identified Zip Codes.

The CPP will also provide outreach programs to focus on prevention and instill healthy behavior habits in residents. This outreach may include neighborhood canvasses, immunization delivery, diet and exercise information dissemination, or other needs identified by Health and Human Services Deputy Chiefs & EMS and CRR Battalion Chiefs. Also, the CPP will provide the residents with medical and mental health resources and referrals to needed levels of care, some of which already exist in the community but remain untapped.

The CP's abilities to visit the patient in their home and perform outreach in the community are critical to the program's success. Home assessments reduce the patient's transportation needs while allowing in-person physical examination and evaluation, permitting the CP to observe the conditions where the patient resides, noting risks and potential improvements within the lived environment. Outreach allows the CPP to go into the community and offer services to patients who may otherwise not seek care for acute illness or chronic disease management.

The CPP will be a critical component of the healthcare system, especially for disadvantaged residents who may experience low income, lack timely access to primary and follow-up mental and physical care, and transportation issues.

This program bridges the gap between the community and mental and general health care services by educating the public regarding healthy behaviors, providing resources, establishing prevention programs, providing effective crisis care, improving outreach, and establishing relationships with professionals providing needed care.

The CPP will be managed by the JFD Deputy Chief of Health Services (with input from the Human Services Deputy Chief), staffed by a grant-funded, full-time Community Paramedic (2023-2026), and supported by a 12-person community paramedicine special team within the JFD. The Community Paramedicine Special Team will be similar to other JFD special teams within the fire department (Hazardous Materials Response, Fire Investigation, Dive/Rescue Team, and Honor Guard). The Community Paramedicine Special Team members will support the full-time Community Paramedic by participating in monthly training and special projects related to the program and assigned by the EMS Battalion Chief.

The CPP will focus on conducting detailed community assessments and defining and confirming specific problems reported in the Will County Community Needs Assessment (2020). The evaluation includes access to healthcare, behavioral health, access to food and nutrition, stabilizing the built environment, and other factors. In addition, chronic diseases listed in the 2017-2020 Will County Health Implementation Plan, such as heart disease, stroke, diabetes, hypertension, obesity, and other illness incidence rates, will be investigated in these and other areas. The result will be community outreach programs to help mitigate these issues.

The CP will provide follow-up care to patients discharged from Silver Cross Hospital &

St. Joseph Medical Center with specific diagnoses of myocardial infarction (heart attack), diabetes, heart failure, pneumonia, and orthopedic issues such as hip and knee replacement. See Section 6: Services for a more detailed look at the processes for each group.

Additionally, the members of the CPP will provide outreach programs to the identified Zip Code areas and among the homeless population, focusing on prevention and instilling healthy behavior habits in residents. These programs may include point-of-care blood testing, immunization delivery, diet and exercise information dissemination, and other services deemed necessary by a completed needs assessment.

In short, to help our residents most effectively, we must be willing to go to them, not require them to come to us. Reaching patients in their homes will reduce the stress on an already overburdened healthcare system, reduce readmissions to local hospitals, and save residents significant money while ensuring they have access to the care they need.

Mental Health Program: 9 Visits

The mental health CPP is divided into hospital discharges and community outreach. The Community Paramedicine Program will provide follow-up care to those discharged from Silver Cross Hospital & St. Joseph Medical Center and ensure the identified Zip Code populations are aware of and have access to the CPP.

While mental and emotional health challenges are not new, the social contexts of individuals within the community and the need for robust care have entered mainstream awareness. Mental health issues affect people from all walks of life and extend beyond those experiencing a mental health issue. Mental health and substance use are the most significant drivers of disability worldwide (WHO, 2022), and access to definitive mental health care is an

important issue. The City of Joliet has partnered with many community stakeholders to provide residents with immediate access to definitive mental health care.

The JFD developed the City of Joliet Community Mental Health Program as a comprehensive and sustainable program to provide residents with timely, definitive mental health care. The mental health program involves three separate tiers to better meet the needs of those with mental and emotional problems and those exposed to traumatic stress-inducing events. The three tiers addressed within this program include an initial response Crisis First Aid for Paramedics (CFA-P), secondary support (local resources), and definitive clinical care (Thriveworks®). This program will work well within the CP framework.

The mental health program allows all residents to see a mental health clinician within 48 hours. In the first year of the program, over 700 residents enrolled in therapy sessions through Thriveworks®.

In our program, residents can see the same therapist as often as needed. These services are free for Joliet residents and covered by most insurances, including Medicaid for all Will County residents. The Community Paramedicine Program ensures that all residents have equal access to mental health care, regardless of socioeconomic status.

In 2021, mental health calls accounted for almost 15% of the annual calls for service (J. Carey, personal communication, November 30, 2022). With the addition of substance abuse calls, mental health issues accounted for almost 20% of the JFD's responses. Mental health issues affect people of all gender, race, ages, and socioeconomic status. Since implementing the JFD Community Mental Health Program, the JFD has seen a 12% drop in behavioral health calls for service and completed suicides dropped by 31% in Joliet comparing CY 2022 & 2023.

One in five adults and one in six children in the US experience mental illness (NAMI, 2022). These statistics imply that approximately 30,000 residents of Joliet suffer from at least one mental health issue. Unfortunately, access and affordability keep less than half of these residents from receiving treatment (Mental Health America, 2023). Of those who receive treatment, an average of eleven years go by from the first symptom until definitive care (NAMI, 2022).

Further, suicide is the second leading cause of death for people ages 10-34 (AFSP, 2021), and twelve teenage suicides occurred in the Joliet area high schools in the 2021-2022 school year (J. Carey, personal communication, May 1, 2023). Additionally, the overall suicide rate in America has increased by 35% since 1999, and 90% of people who die by suicide have experienced mental illness.

The costs of untreated mental health disorders extend far into the community beyond the mental health patient. According to the National Alliance on Mental Illness (NAMI), 70% of youth in the juvenile justice system have at least one mental health condition (2022). NAMI (n.d.) also estimates that untreated mental illness costs the US up to $300 billion annually due to lost productivity and associated costs due to absenteeism, employee turnover, and medical and disability expenses increases. Over eight million caregivers of adults with mental or emotional health issues spend an average of 32 hours per week providing unpaid care (NAMI, n.d.).

The primary problems with definitive mental health care are access, cost, and transportation. For people with insurance, a clinical care first appointment in Joliet can take 4-6 weeks for basic care and 15-16 weeks for advanced care. It is difficult for the uninsured or underinsured to get the needed treatment. Because a person with a mental health issue may not be able to access care, afford care, or have transportation to care, they may call an ambulance

and request transport to the hospital emergency department (ED), where there is minimal treatment for the mental health patient. The patient enters a repeating cycle of calling the ambulance to take them to the ED and being sent home with no definitive care ever being done.

Lastly, according to the Centers for Disease Control and Prevention (CDC), the COVID-19 pandemic exacerbated severe issues such as suicide, substance abuse, anxiety, and depression for high school-aged Americans. Further, according to the American Foundation for Suicide Prevention (AFSP), the suicide rate for teens and young adults aged 15-24 nationwide was 14.24 per 100,000 in 2020 (n.d.). A study performed by Bitsko et al. (2022) and reported by the CDC found that among 12–17-year-old Americans, 18.8% seriously considered attempting suicide, 15.7% made a suicide plan, 8.9% attempted suicide, and 2.5% made a suicide attempt requiring medical treatment. According to the Will County Community Needs Assessment (2020), 16% of 12th and 14% of 10th graders in Will County indicated that they have considered suicide in the last year.

Substance abuse is also a critical issue within this age group nationwide. According to Bitsko et al. (2022) and the CDC, among 12–17-year-olds, 4.1% reported a substance use disorder, 1.6% reported an alcohol use disorder, and 3.2% reported an illicit drug use disorder. This issue extends into Will County, where, in 2108, 23% of 12th graders reported binge alcohol consumption in the last two weeks, and 45% of 12th graders said they were using alcohol.

Anxiety is one of the most common issues among teens. According to the National Institute of Mental Health (NIMH) (n.d.), an estimated 31.9% of adolescents have an anxiety disorder of some type. An estimated 8.3% had severe impairment among those with an anxiety disorder.

Bitsko et al. (2022) also discuss the depression issue among teens. In their study, in 2018-2019, 15.1% had a major depressive episode, and 36.7% had persistent feelings of sadness or hopelessness. This problem manifests locally as well. According to the Will County Community Needs Assessment (2020), 35% of 12th graders in Will County said they felt so sad or hopeless almost every day for two weeks or more in a row and that they stopped doing some usual activities in the past year.

Hospital Discharges:

The CPP will build on the JFD Community Mental Health Program by performing home visits with those discharged from the Behavioral Health Units at Silver Cross Hospital & St. Joseph Medical Center to ensure medication compliance and refer definitive care.

Ideally, this will be done while a patient is admitted to the facility. The CP will be informed of the patient by the hospital, and the CP will visit them and offer services. If this is not possible (i.e., the patient is released from the ED), the team member will contact the person at home to offer services. After discharge, the CP special team members will respond to these patients at their homes following the policies and procedures in this manual.

Community Outreach:

The CPT will schedule regular outreach events in the identified Zip Codes. Churches, community centers, schools, fire stations, and other locations may be used. These events may offer Crisis First Aid and mental health referral services.

Physical Health Program: 6 Visits

The program is divided into hospital discharges and community outreach.

Hospital discharges:

Ambulance call responses and specific medical discharge diagnoses from Silver Cross Hospital & St. Joesph Medical Center will be offered follow-up CP care. Ideally, this will be done while a patient is admitted to the facility. The CP will be informed of the patient by the hospital, and the CP will visit them and offer services. If this is not possible (i.e., the patient is released from the ED), the team member will contact the person at home to offer services. After discharge, the full-time CP will respond to these patients at their homes following the policies and procedures in this manual.

Community Outreach:

The CPP will schedule regular outreach events in the identified Zip Codes. Churches, community centers, schools, fire stations, and other locations may be used. These events may offer medical assessments, blood pressure checks, EKGs, education, medication explanations, immunization clinics, physician referral services, and other needed help.

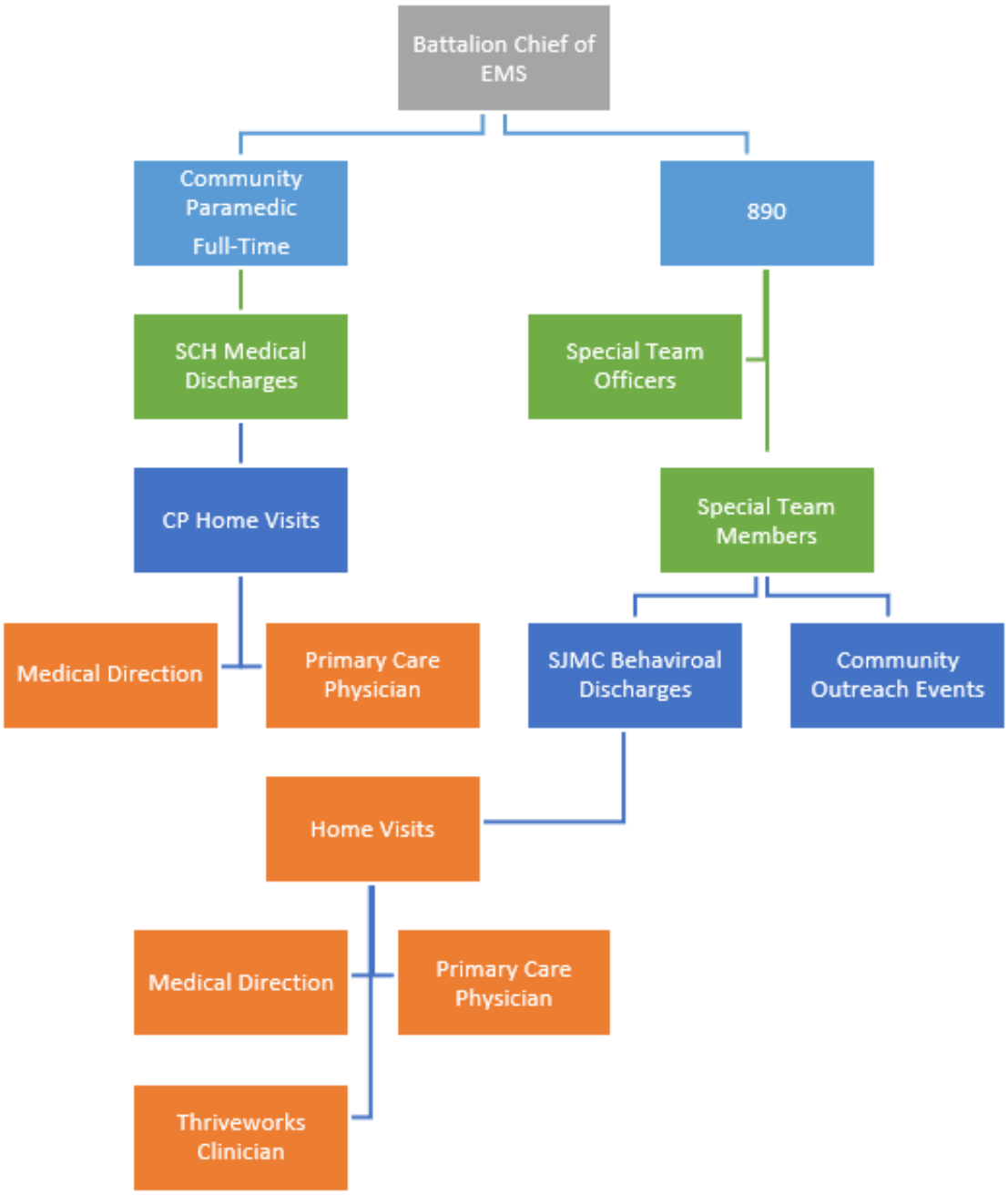
A robust CPP will ensure that people can meet their general health needs at home when they cannot reach their doctor or ED. A CPP will prepare the community for another pandemic by providing general and mental healthcare and vaccinations to homebound and underserved patients.

CP General Function

- Coordinating health services for patients/clients.
- Determining the need for and providing referrals to community resources (such as mental health, substance abuse, public health, and social services).
- Assessing safety risks for the community paramedic (for example, unsafe situations, animals, and diseases).

- Assessing safety risks for the patient/client (for example, disease, falls, and environmental health hazards).
- Assessing the patients' experiences in their work environment.
- Educating on the proper use of healthcare resources.
- Educating on identified healthcare goals.
- Performing a physical safety inspection (home, property, and vehicle).
- Screening for chronic diseases (diabetes, asthma, and coronary artery disease).
- Providing service with the local public health agency (for example, immunization and disease investigation).
- Providing service with the local social service and aging agencies (for example, adult protection, child protection, senior services, and housing).
- Participating in wellness clinics (such as immunization and screening).

Section 4: Joliet Fire Department CPP Structure



The initially planned structure of the JFD CPP includes a two-tier configuration consisting of one full-time community paramedic under the supervision of the JFD Battalion Chief in charge of EMS. The CP will manage the medical aspect of the program and perform follow-up visits to defined medical patients discharged from Silver Cross Hospital. The CPT of 12 members of the JFD will be formed to work part-time and manage mental health follow-up visits to behavioral patients discharged from St. Joesph Medical Center and community outreach. The Fire Chief or their designee will select the members of this team.

The full-time CP will have the following responsibilities:

1. Updated reporting to the Battalion Chief in charge of EMS regarding CPP assignments and training.
2. Coordinating training for the special team CPs

The special teams CPs will have the following responsibilities:

1. Regular attendance at quarterly CP training.
2. Mental health home visits as assigned by the EMS Division.
3. Community outreach event organization and participation.

Quarterly Training

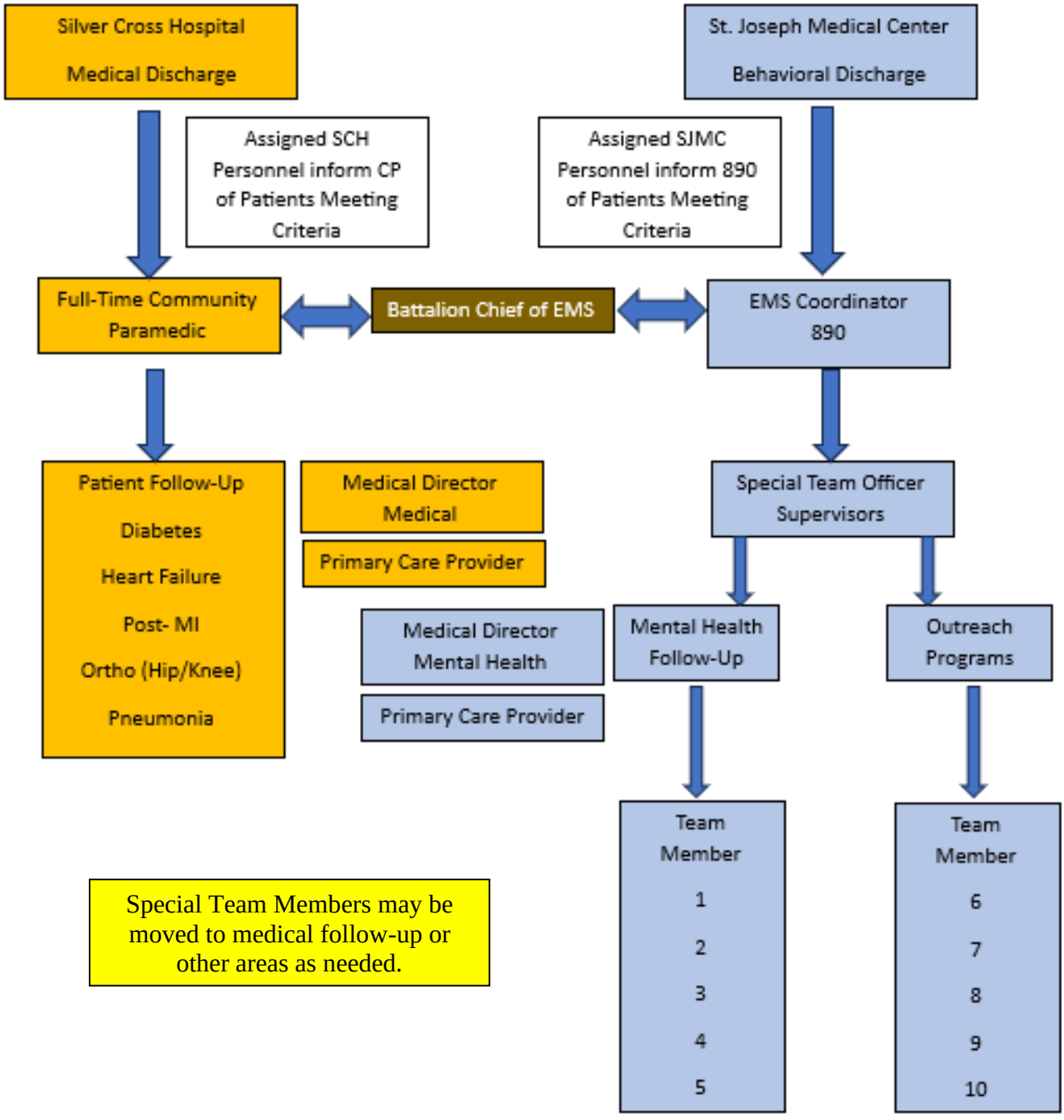
The BC of EMS or their designee will organize and complete quarterly training for the members and determine the topics, dates, and duration.

Connection to JFD Community Risk Reduction (CRR) and Community Mental Health

The patient may experience many challenges outside the medical realm that affect health. The CP should know how to access services outside their scope of practice. The CP must be familiar with their provided services and additional services offered by the Community Risk

Reduction, Community Care, and Community Mental Health programs and make referrals as needed. These needs may include transportation, prescription drug pick-up, home repairs, etc.

JFD Community Paramedicine Flowchart



Section 5: Will County Community Needs Assessment & Will County Health Implementation Plan

The Will County Community Needs Assessment identified four primary areas for improvement. These areas include access to healthcare, behavioral health, stabilizing the built environment, and access to food and nutrition. Two of the four primary needs listed are most appropriate to the CP program. These include access to healthcare and behavioral health.

In addition, chronic diseases listed in the 2017-2020 Will County Health Implementation Plan, such as heart disease, stroke, diabetes, hypertension, obesity, and other illness incidence rates, will be investigated.

Access to Healthcare

Primary Health Care

The CPP will provide equitable, culturally, and linguistically competent care, health literacy, and progress monitoring to those with private insurance, Medicaid recipients, and Medicare recipients in area codes 60432, 60433, 60435, and 60436.

Chronic Disease

The CPP will provide health care services to prevent or enable early disease detection, reduce risk factors, and manage conditions. The program also addresses strategies that link community and clinical services to ensure that people with or at high risk of chronic diseases have access to the resources they need to prevent or manage these diseases. This is especially true in the Medicare population, males, African Americans, and area codes 60432, 60433, 60435, and 60436.

Behavioral Health

The CPP will provide equitable access to behavioral health services, resources, providers, and progress monitoring to the 60432, 60433, 60435, and 60436 Zip Codes.

The JFD CP will be a critical component of the healthcare system, especially for disadvantaged residents who may experience low income, lack timely access to primary mental health and physical care, and have transportation issues. These residents are the primary target population for the grant, as the pandemic has disproportionately impacted people within these households and communities.

Section 6: CP Services

Enrollment Visit

Introduction and Explanation

Medication Inventory

Ending the Visit

Intake Visit

Patient Assessment

Patient Needs Assessment

Plan of Care

Follow-Up Visits

Patient Assessment

Goal Evaluation

End of Care Visit

Disenrollment Visits

Patient Education

Documentation

Outreach

Patient Assessment

The patient assessment lays the groundwork for the plan of care and is a critical part of the Community Paramedic's duties. While the Community Paramedic does not diagnose, they aid in managing physician-diagnosed issues. Assessment includes:

1. General Information
2. Chief Complaint

3. History of the present illness
4. Past medical history
5. Family medical history
6. Social history
    a. Activities of daily living and interests
    b. Coping strategies
    c. Social support
    d. Fears
    e. Perceived weaknesses
    f. Occupation
7. Medications
    a. Over the counter
    b. Prescription
    c. Compliance
8. Allergies
9. General Assessment
10. Vital Signs
    a. Blood pressure
    b. Pulse
    c. Respirations
    d. Temperature
    e. Oxygen saturation
    f. End-tidal co2

g. Blood glucose level, other PoC

h. Skin condition

i. Weight and height

j. Pupils

k. Lung sounds

Patient Needs Assessment

The patient needs assessment is a tool that enables the community paramedic to gather important information about the patient that extends beyond the working diagnosis, considering factors such as the patient's health history, living environment, and social network. It includes a thorough evaluation that helps determine all patient needs, from transportation to healthcare to social services. This complete patient evaluation separates the patient needs assessment from the general assessment for paramedics.

Sources of information for the patient needs assessment may come from the following:

1. Research
    a. If possible, the patient's electronic medical records
    b. Physicians' plan of care
    c. Discharge plan
2. Interview. Consider the following:
    a. Ability to perform self-care.
    b. Care capacity within the home
    c. Cognitive and functional needs of the patient
    d. Patient's ability to understand and explain
    e. Current access to support services

   f. Current access to outreach services such as grocery stores or pharmacy delivery, meal delivery
   g. Cultural values

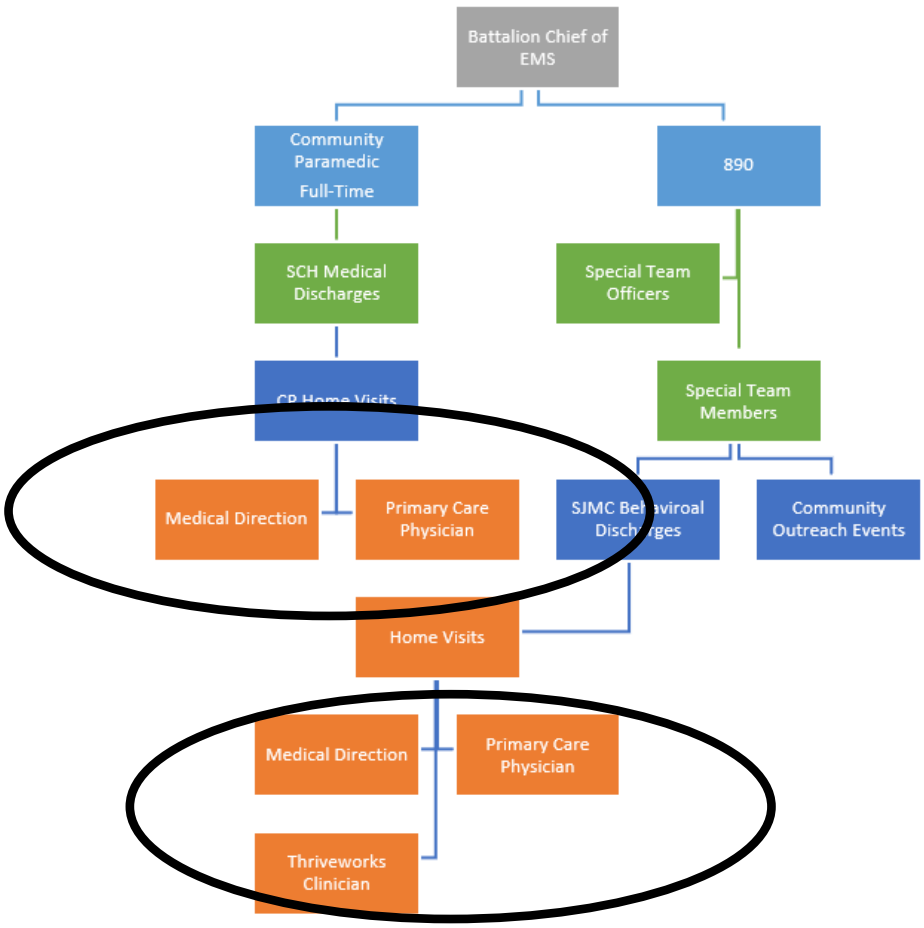
3. Evaluation. Consider the following:
   a. Air quality of the home
   b. The overall condition of the structure
   c. Cleanliness
   d. Smoke detectors
   e. Carbon monoxide detectors
   f. Condition of walkways, stairs, and floors
   g. General safety concerns such as loose carpeting, etc.
4. Work
   a. Physical environment
   b. Benefits to employees
5. Goals
   a. Patient
   b. Physician
6. Documentation
   a. Brief description
   b. Form completion
   c. Observations
7. Plan of Care Development
8. Lab Value Explanations

9. Chronic Disease Management
10. Mental Health Care
11. Immunizations
12. Education: Nutrition
13. Education: Exercise
14. Education: Electronic Patient Records

Section 7: Medical Direction

A critical component of the CPP is medical direction. The CP does not act independently but under the authority of a medical director and the patient's primary care physician. If necessary, the CP may contact the medical director (either by telephone or video conferencing) from the field to discuss care.

The development of the community paramedicine program relies on the initial search for a suitable medical director(s). The Fire Chief and EMS BC will work with the local hospitals to determine the best physician to direct the program components. The Silver Cross Emergency Medical Services System offers medical direction for emergency transports within Joliet. They have expressed interest in partnering with the JFD to guide the CPP.



Section 8: Required Training and Certification

CP is a discipline separate from emergency response. As such, it requires unique training and certification. The general and specific requirements for the position are detailed below.

Requirements for Full-Time CP Position:

- Selected by Local 44 bid process.
- Successful completion of the education requirement upon assumption of bid (see section below).
- Successful credentialing through the International Board of Specialty Certification (IBSC) (see the selection below).
- Successful completion of *Culturally Competent Nursing Care: A Cornerstone of Caring* through The U.S. Department of Health and Human Services Office of Minority Health (OMH).
- Successful completion of the Centers for Disease Prevention and Control (CDC) STEADI Program.

Requirements for Special Team CP Members:

- IDPH Licensed Paramedic with:
    - Excellent patient assessment skills
    - The ability to work collaboratively as a member of a healthcare team.
    - Good communication and social skills
    - Empathy
    - Acceptable EMS System and EMS Agency personnel file upon review.
- Field experience for a minimum of two years
- Application letter to the Fire Chief detailing reasons for the application

- Interview by Chief or Designee and Program Manager
- Successful completion of the education requirement (see section below)
- Successful credentialing through the International Board of Specialty Certification (IBSC) (see the selection below)
- Successful completion of *Culturally Competent Nursing Care: A Cornerstone of Caring* through The U.S. Department of Health and Human Services Office of Minority Health (OMH)
- Successful completion of the Centers for Disease Prevention and Control (CDC) STEADI Program.
- The Fire Chief and Coordinator may offer preference or non-adherence to the field experience requirements due to the following:

  Special medical training (e.g., nursing license, current CP-C Certification, etc.)

  Special skills detailed in the application letter.

  Spanish language speakers due to community need

Training

Training will be provided and paid for by the Joliet Fire Department

- Columbia Southern University CE 1300: Certified Community Paramedic Review Course
- *Culturally Competent Nursing Care: A Cornerstone of Caring*
- Centers for Disease Control and Prevention (CDC) STEADI (Stopping Elderly Accidents, Deaths and Injuries) Training

Columbia Southern University CE 1300: Certified Community Paramedic Review Course

A paramedic assigned to a position with CP responsibilities will complete CE 1300: Certified Community Paramedic Review Course through Columbia Southern University. It is an online course and will be provided by the JFD.

This course will assist in preparing the student for the International Board of Specialty Certification (IBSC) Certified Community Paramedic (CP-C) examination, which can lead to the CP-C designation. It is geared toward the paramedic proficient in the current national standards for paramedics. It is specific to patient-centered care, interdisciplinary collaboration, community needs, disease/injury prevention, and community and patient education.

Textbook(s)

All course materials are included in the course at no additional fee.

- Nies, M. A., & McEwan, M. (2019). *Community/public health nursing: Promoting the health of populations.* Saunders

Additional Course Information

Students will review the presentations in each of the four units and complete an assessment of the content. Students cannot move to the next unit until they successfully pass the previous unit assessment with an 80% or higher to ensure they grasp concepts. Students may contact the instructor if they are struggling with specific ideas.

Course Learning Objectives:

- Define determinants of health.
- Recognize the role of community paramedics in addressing community-based needs.
- Describe health promotion strategies.
- Identify components commonly found in a patient's plan of care.

- Discuss the importance of interprofessional disciplinary collaboration for proper patient care.
- Relate ethical and legal considerations of care.
- Recognize the factors that affect the monitoring and management of the chronic disease patient.
- Apply knowledge of the principles of care.

A certificate of completion with the number of CEUs awarded will be issued upon completing the course. The course must be paid for in full before the student can receive a certificate of completion.

Enrollment Details (as of 2023)

- Tuition: $325
- Course Credits: 9.0 CEUs

Certification

The CP-C Examination

Community Paramedicine is an emerging healthcare delivery model that increases access to essential services by utilizing specially trained emergency medical service (EMS) providers in an expanded role. Community Paramedics care for patients at home or in other non-urgent settings outside of a hospital under the supervision of a physician or advanced practice provider. Community Paramedics can expand the reach of primary care and public health services by using EMS personnel to perform patient assessments.

Over the past decade, local healthcare gaps around the US and internationally have been filled through Community Paramedic programs that use EMS personnel to fill gaps in the healthcare system, particularly in round-the-clock management of non-acute illnesses, mental health issues, and chronic care follow-up needs. The Community Paramedic is ideally suited to

provide better care through non-emergency interaction with community patients, integration, coordination with various needed services, and improved patient navigation. Community Paramedic services will help reduce unnecessary trips to the emergency department, reduce readmission to the hospital, improve the patient's quality of life, and decrease overall healthcare costs.

Community Paramedic Exam Candidates

The expectation for the CP-C exam candidate is competency in mobile integrated healthcare and expanded EMS services in rural and urban settings, including various healthcare, mental health, housing, and social service needs. This examination is not meant to test entry-level knowledge but to validate the competency of paramedics providing services beyond traditional emergency care and transport roles.

CP-C Eligibility

To obtain certification, the candidate must hold an unrestricted license or certificate to practice as an EMT, paramedic, or other nursing or community health worker with appropriate education and training as defined by local regulations.

Community Paramedic Certification Renewal Information

The purpose of the recertification program is to support the continuous competence and professional development of IBSC certificates. The Certified Community Paramedic (CP-C) recertification cycle is every four (4) years. During the four years, continuing education and position duties that exemplify continued growth in safety-related education in the critical care transport industry must be demonstrated.

Recertification can be achieved in one of two ways:

1. Successfully retake the written certification examination

2. Complete the required recertification hours

Culturally Competent Nursing Care: A Cornerstone of Caring

The US Department of Health and Human Services provides cultural and linguistic awareness training for various care providers, a cornerstone of this program. While they offer a course for emergency and disaster response (which all firefighters should take), there is no program for community paramedicine. There is, however, a version for nursing staff that is appropriate for this program.

Culturally Competent Nursing Care: A Cornerstone of Caring is a free e-learning program from the HHS Office of Minority Health. It is accredited for up to 9 continuing education credits, at no cost.

This e-learning program helps deliver culturally and linguistically competent care. Cultural and linguistic competency is the capacity for individuals and organizations to work and communicate effectively in cross-cultural situations. Cultural and linguistic competency can help improve the quality of the care delivered to patients from diverse cultural backgrounds.
This e-learning program is grounded in the *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care*. These *Standards* are intended to advance health equity, improve quality, and help eliminate health disparities. The *National CLAS Standards* provide health professionals with a blueprint for increasing cultural and linguistic competency.

Centers for Disease Control and Prevention (CDC) STEADI (Stopping Elderly Accidents, Deaths, and Injuries) Training

Falls are a significant cause of ED visits and readmissions. The CDC STEADI Program is an online fall prevention program developed to proactively assess, screen, and mitigate fall

hazards for older adults. It educates CP responders to evaluate patients who have fallen or are at risk of falling to ensure steps are taken to reduce the potential for future issues.

Fall history, comorbidities such as osteoporosis management, gait, strength, balance, medication assessment, orthostatic hypotension management, visual acuity assessment, referrals to evidence-based fall prevention programs, physical therapy, occupational therapy, podiatrists, and eye care professions are discussed.

Appendix A: JFD Community Paramedicine Policy/Procedure

Note: All Region 7 Standard Medical orders (SMO) must be followed in an emergency.

CP Policy 1: Care Process: (Medical)

1. Patient selection
    a. Patients must live within the Zip Codes 60432, 60433, 60435, and 60436.
    b. Patients should have one or more of the following.
        - Frequent all-cause ED utilization.
        - Frequent admission for a chronic condition.
        - Frequent 911 utilization.
        - Documented barriers to care participation (financial, transportation, education).
        - High risk for readmission on discharge.
    c. The Hospital Case Manager (CM)/Assigned CP should speak with all patients about CP before referring them to the program.
2. Submitting a referral
    a. CMs can submit patient referrals via email to CPP@joliet.gov
    b. The referral should include.
        - Patient's name
        - DOB
        - Address & phone number
        - Primary Care Provider (PCP)
        - Problem list/goals
3. Scheduling a visit
    a. JFD personnel will receive referrals and confirm with submitting CM via email.
    b. JFD will attempt to arrange the first visit within 72 hours of receiving the referral.
    c. JFD will make three attempts to contact the patient.
        - If unable to contact or the patient refuses CP, the referral will be closed through the same email chain.
    d. If patient contact is successful, and the patient agrees to CP;
        - The first visit will be scheduled in coordination with the referring CM.
4. CP Visits
    a. Week 1 – Program Introduction & Assessment
        - During the visit
            - Consents
            - Patient assessment – health, home, knowledge, needs, barriers to care.
            - Safety assessment – Home safety survey, personal safety, suicide screening, food insecurity
            - Medication reconciliation – knowledge of meds, availability/affordability, compliance
                - Ask if the medications are helping the person or meeting their needs.
            - Ask the patient what their goals are.
        - After the visit

    - Develop a safety plan.
    - Coordinate with PCP
    - Develop goals for the CP program.
        - 3 short-term & 2 long-term

b. Week 2 – Present Patient Plan/ Education
    - Provide a safety plan for the patient.
        - If not done on the first visit, provide resources and education to address safety issues.
    - Present CP plan, incorporating patient goals.
        - Provide strategies for overcoming identified barriers.
    - Provide disease/condition-specific education
    - Medication reconciliation – if not done on the first visit
c. Week 3 – Work toward achieving short-term goals.
    - Reassess for care plan participation.
    - Assess the effectiveness of education.
    - Work to remove identified barriers to care.
    - Goal-specific work
d. Week 4 – Reinforcement and Resiliency
    - Continue goal-specific work.
    - Reinforce the care plan.
    - Provide strategies for independence/self-advocacy.
e. Visit 5- Follow up.
    - It may occur up to 2 weeks after visit 4
    - Reinforce independence.
    - Reinforce care plan participation.
f. Visit 6 – Graduation
    - It may occur two weeks after visit 5
    - Patients who have met their short-term goals and are working earnestly toward their long-term goals are graduated from the program at this visit.

Policy 2: Care Process (Mental Health)

1. Patient selection

    a. Patients must live within the Zip Codes 60432, 60433, 60435, and 60436.
    b. Patients **MUST** have a diagnosed psychiatric condition **AND** one or more of the following;
        - Frequent all cause ED utilization
        - Frequent psychiatric admission
        - Frequent 911 utilization
        - Documented barriers to care participation (financial, transportation, education)
        - High risk for readmission on discharge
    b. The Hospital Case Manager (CM)/Assigned CP should speak with all patients about CP before referring them to the program.

2. Submitting a referral

    a. RNs can submit patient referrals via email to CPP@joliet.gov
    b. The referral should include;
        - Patient's name
        - DOB
        - Address & phone number
        - PCP & Clinician
        - **Psych Dx/problem list/goals**

3. Scheduling a visit

    a. JFD personnel will receive referrals and confirm with the submitting RN via email.
    b. JFD will attempt to arrange the first visit within 72 hours of receiving the referral.
    c. JFD will make three attempts to contact the patient
        - If unable to contact or the patient refuses CP, the referral will be closed through the same email chain.
    d. If patient contact is successful, and the patient agrees to CP;
        - The first visit will be scheduled

4. CP Visits

    a. Week 1 – Program Introduction & Assessment

        i. During the visit
            - Consents
            - Patient assessment – health, home, knowledge, needs, barriers to care
            - Safety assessment – Home safety survey, personal safety, suicide screening, food insecurity

- Medication reconciliation – knowledge of meds, availability/affordability, compliance
- Ask if the medications are helping the person or meeting their needs
- Ask the patient what their goals are

ii. After the visit
- Develop a safety plan
- Coordinate with PCP/Psychiatrist/Thriveworks
  - JFD to coordinate with PCP
  - RN to coordinate with Psychiatrist/Thriveworks
  - RN & CP to collaborate if PCP manages psych dx.
- Develop goals for the CP - MH program
  - 3 short-term & 2 long term

b. Week 2 – Present Patient Plan/ Education
- Provide a safety plan for the patient
  - If not done on the first visit, provide resources and education to address safety issues.
- Present CP plan, incorporating patient goals
  - Provide strategies for overcoming identified barriers
- Provide disease/condition-specific education
- Medication reconciliation – if not done on the first visit

c. Week 3 – Work toward achieving short-term goals
- Reassess for care plan participation
- Assess the effectiveness of education
- Work to remove identified barriers to care
- Goal specific work

d. Week 4 – Reinforcement and Resiliency
- Continue goal-specific work
- Reinforce the care plan
- Provide strategies for independence/self-advocacy

e. Visit 5- Follow up
- Reinforce independence
- Reinforce care plan participation

f. Visit 6 – Follow up and transition to bi-weekly check-in

g. Visits 7 & 8
- Reassess patient participation and progress toward goals

h. Visit 9 – Graduation
- Patients who have met their short-term goals and are working earnestly toward their long-term goals are graduated from the program at this visit.

Policy 3: Medical Visit 1

Week 1 – Program Introduction & Assessment

During the Week 1 visit, the CP will perform the following activities:

- During the visit
  - Consents
  - Patient assessment – health, home, knowledge, needs, barriers to care.
  - Safety assessment – Home safety survey, personal safety, suicide screening, food insecurity
  - Medication reconciliation – knowledge of meds, availability/affordability, compliance
    - Ask if the medications are helping the person or meeting their needs.
  - Ask the patient what their goals are.
- After the visit
  - Develop a safety plan.
  - Coordinate with PCP
  - Develop goals for the CP program.
    - 3 short-term & 2 long-term
- Documentation

Policy 4: Medical Visit 2

Week 2 – Present Patient Plan and Education

During the Week 2 visit, the CP will perform the following activities:

- Patient assessment/focused assessment
- Provide a safety plan for the patient.
    - If not done on the first visit, provide resources and education to address safety issues.
- Present CP plan, incorporating patient goals.
    - Provide strategies for overcoming identified barriers.
- Provide disease/condition-specific education.
    - Medication reconciliation – if not done on the first visit
- Documentation

Policy 5: Medical Visit 3

Week 3 – Work Toward Short-Term Goals

During the Week 3 visit, the CP will perform the following activities:

- Patient assessment/focused assessment
- Reassess for care plan participation.
- Assess the effectiveness of education.
- Work to remove identified barriers to care.
- Goal-specific work
- Documentation

Policy 6: Medical Visit 4

Week 4– Reinforcement and Resiliency

During the Week 4 visit, the CP will perform the following activities:

- Patient assessment/focused assessment
- Continue goal-specific work.
- Reinforce the care plan.
- Provide strategies for independence/self-advocacy.
- Documentation

Policy 7: Medical Visit 5

Week 5 – Follow-up may occur up to 2 weeks after Visit 4

During the Week 5 visit, the CP will perform the following activities:

- Reinforce independence.
- Reinforce care plan participation.
- Documentation
- It may occur up to 2 weeks after visit 4

Policy 8: Medical Visit 6

Week 6 – Graduation

During the Week 6 visit, the CP will perform the following activities:

- It may occur two weeks after Visit 5
- Patients who have met their short-term goals and are working earnestly toward their long-term goals graduate from the program at this visit.
- Documentation

Policy 9: Behavioral Visit 1

Week 1 – Program Introduction and Assessment

During the Week 1 visit, the CP will perform the following activities:

- During the visit
  - Consents
  - Patient assessment – health, home, knowledge, needs, barriers to care.
  - Safety assessment – Home safety survey, personal safety, suicide screening, food insecurity
  - Medication reconciliation – knowledge of meds, availability/affordability, compliance
    - Ask if the medications are helping the person or meeting their needs.
  - Ask the patient what their goals are.
- After the visit
  - Develop a safety plan.
  - Coordinate with PCP/Psychiatrist/Thriveworks
  - Develop goals for the CP program.
    - 3 short-term & 2 long-term
- Documentation

Policy 10: Behavioral Visit 2

Week 2 – Program Introduction and Assessment

During the Week 1 visit, the CP will perform the following activities:

- Patient assessment/focused assessment
- Provide a safety plan for the patient.
    - If not done on the first visit, provide resources and education to address safety issues.
- Present CP plan, incorporating patient goals.
    - Provide strategies for overcoming identified barriers.
- Provide disease/condition-specific education.
    - Medication reconciliation – if not done on the first visit
- Documentation

Policy 11: Behavioral Visit 3

Week 3 – Work Toward Short-Term Goals

During the Week 3 visit, the CP will perform the following activities:

- Patient assessment/focused assessment
- Reassess for care plan participation.
- Assess the effectiveness of education.
- Work to remove identified barriers to care.
- Goal-specific work
- Documentation

Policy 12: Behavioral Visit 4

Week 4– Reinforcement and Resiliency

During the Week 4 visit, the CP will perform the following activities:

- Patient assessment/focused assessment
- Continue goal-specific work.
- Reinforce the care plan.
- Provide strategies for independence and advocacy
- Documentation

Policy 13: Behavioral Visit 5

Week 5 – Follow-Up

During the Week 5 visit, the CP will perform the following activities:

- Patient assessment/focused assessment
- Reinforce independence.
- Reinforce care plan participation.
- Documentation

Policy 14: Behavioral Visit 6

Week 6 – Follow-Up and Transition to Bi-Weekly Check-In

During the Week 6 visit, the CP will perform the following activities:

- Patient assessment/focused assessment
- Patients who have met their short-term goals and are working earnestly toward their long-term goals graduate from the program at this visit.
- Documentation

Policy 15: Behavioral Visits 7 and 8

Week 7 and 8 – Follow-Up

During the Week 7 and 8 visits, the CP will perform the following activities:

- Patient assessment/focused assessment
- Reassess patient participation and progress toward goals
- Documentation

Policy 16: Behavioral Visit 9

Week 9 – Graduation

During the Week 9 visit, the CP will perform the following activities:

- Patient assessment/focused assessment
- Patients who have met their short-term goals and are working earnestly toward their long-term goals graduate from the program at this visit.
- Documentation

Policy 17: Disenrollment Visits

If a patient is non-compliant with stated program goals and objectives, the CP may perform a disenrollment visit. During this visit, the CP will discuss the issues with the patient to find a potential solution. If no resolution is reached, the patient will receive a disenrollment form.

Reasons for disenrollment

- Non-compliant with the care program
- Miss two appointments in a row without cause
- The patient is belligerent or harassing

Appendix A: Qualified Census Tract/Zip Codes

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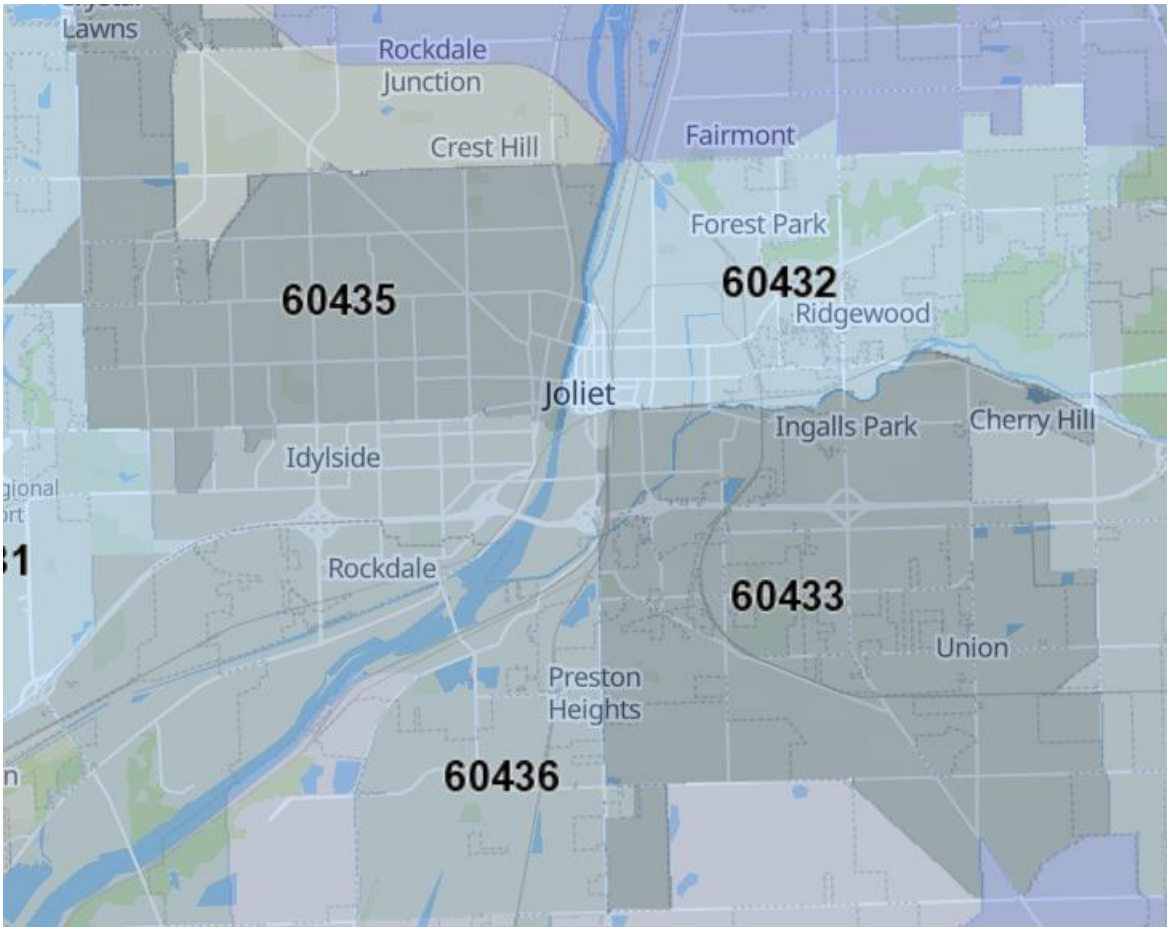
Lawns
Rockdale
Junction
Crest Hill
Fairmont
Forest Park
60435
60432
Ridgewood
Joliet
Ingalls Park
Cherry Hill
Idylside
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Union
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Heights
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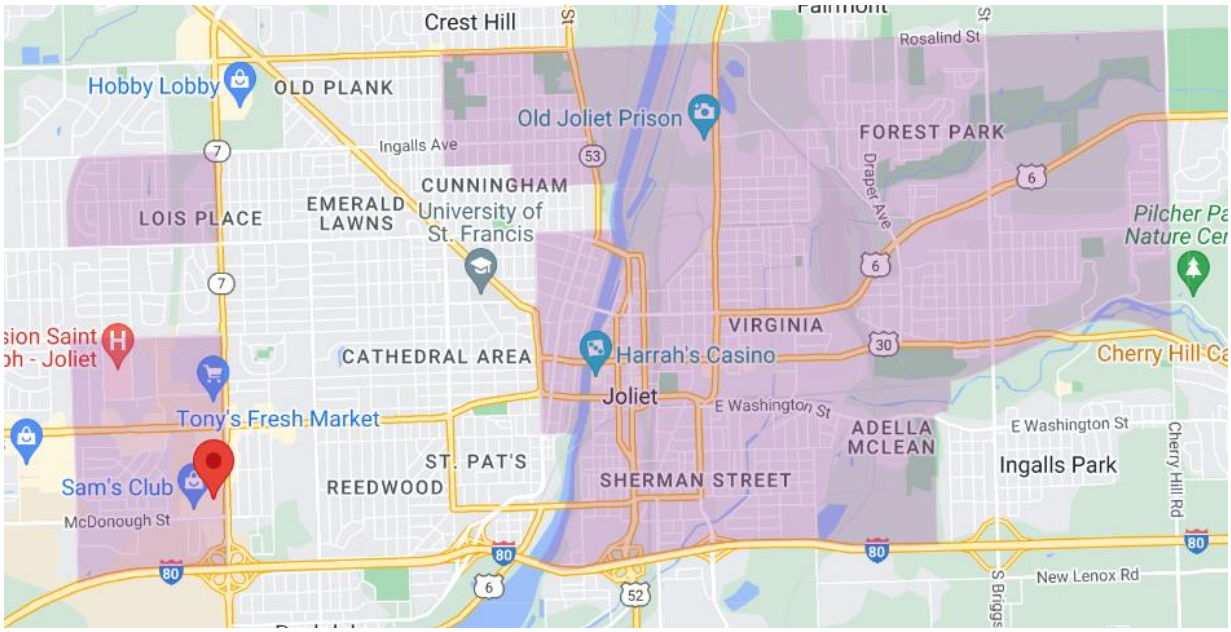
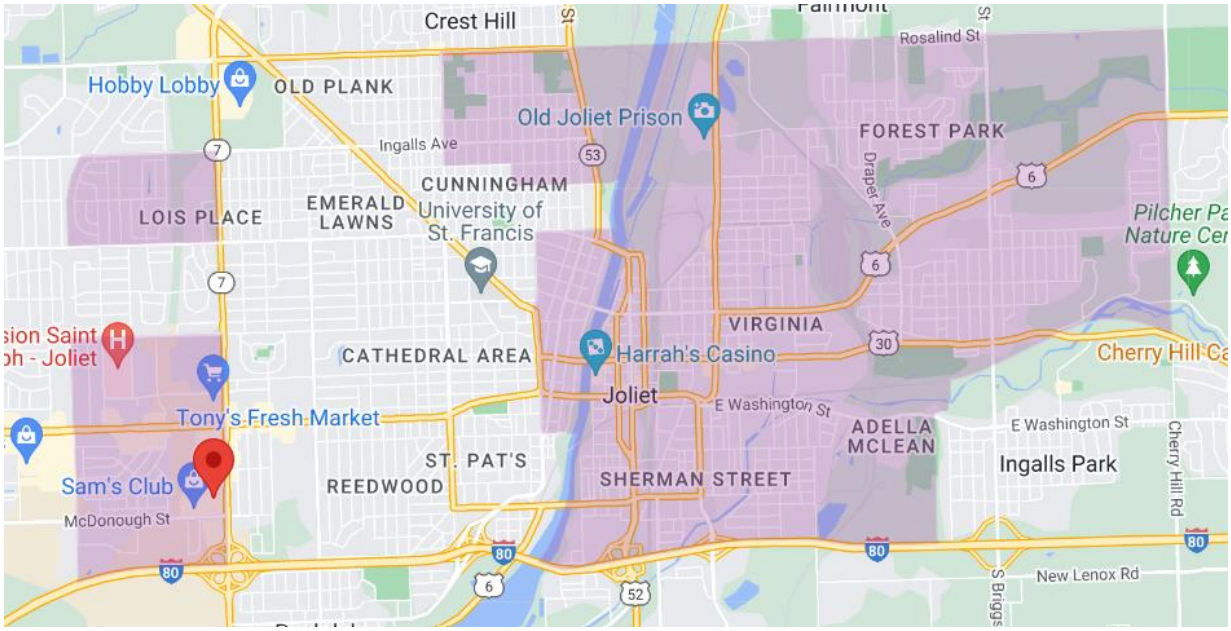

Crest Hill
Rosalind St
Hobby Lobby
OLD PLANK
Old Joliet Prison
FOREST PARK
Ingalls Ave
CUNNINGHAM
EMERALD
LAWNS
University of
St. Francis
LOIS PLACE
Draper Ave
VIRGINIA
CATHEDRAL AREA
Harrah's Casino
Joliet
Tony's Fresh Market
E Washington St
ADELLA
MCLEAN
ST. PAT'S
REEDWOOD
SHERMAN STREET
Ingalls Park
Sam's Club
McDonough St
New Lenox Rd

Qualified Census Tracts, Joliet & Potential Community Partners



- Tract 8812.01: Population 2,095
  - Forest Park Community Center
  - JFD Station 4
- Tract 8812.02: Population 2,460
- 8813.02
  - Our Lady of Mt. Carmel
  - St. Joseph's Church
- 8814.01
  - St. Joe's Park
- 8816.03
  - Hufford Jr. High
- Tract 8819: Population 3,725
  - St. Mary Nativity
  - St. John the Baptist
- Tract 8820: Population 3,445
  - Christ Temple Apostolic Church
  - JFD Station 1
  - Joliet Central High School
- Tract 8821: Population 2,596
  - Bethlehem Lutheran Church
  - Full Gospel Community Fellowship Church
  - JFD Station 4
- 8813.01
  - Holy Hills Deliverance Church
  - Iglesia Cristo es la Roca
    - JFD Station 1
- Tract 8822: Population 3,934
  - St. Bernard's Catholic Church
- Tract 8824: Population 3,392
  - Apostolic House of God
- Tract 8825: Population 2,246
  - Sacred Health Catholic Church
- Tract 8826.02: Population 2,842
  - Joliet Fire Station 6
  - St. Jude's Catholic Church
- Tract 8828.02: Population 3,018
  - Northern Illinois Food Bank
  - Redeem Enrichment Ministries

- Tract 8812.01: Population 2,095
- Tract 8812.02: Population 2,460
- Tract 8813.01: Population 3,040
- Tract 8813.02: Population 1,307
- Tract 8814.01: Population 3,418
- Tract 8816.03: Population 3,301
- Tract 8819: Population 3,725
- Tract 8820: Population 3,445
- Tract 8821: Population 2,596
- Tract 8822: Population 3,934
- Tract 8824: Population 3,392
- Tract 8825: Population 2,246
- Tract 8828.02: Population 3,018

Search for address or place...

Vulnerability

Tract 8812, Will County, IL

Overall Vulnerability	0.81
Socioeconomic Status	0.88
Minority Status & Language	0.86
Household & Transportation	0.83
Epidemiological Factors	0.30
Healthcare System Factors	0.99
High Risk Environments	0.10
Population Density	0.48

Race +

Elevated Health Risk (EHR) Individuals +

COVID-19 Stats +

Test Sites and Mobility +

Critical Risk Workers +

Share your findings:

For more information, contact Surgo's COVID-19 team at **covid19@surgoventures.org**

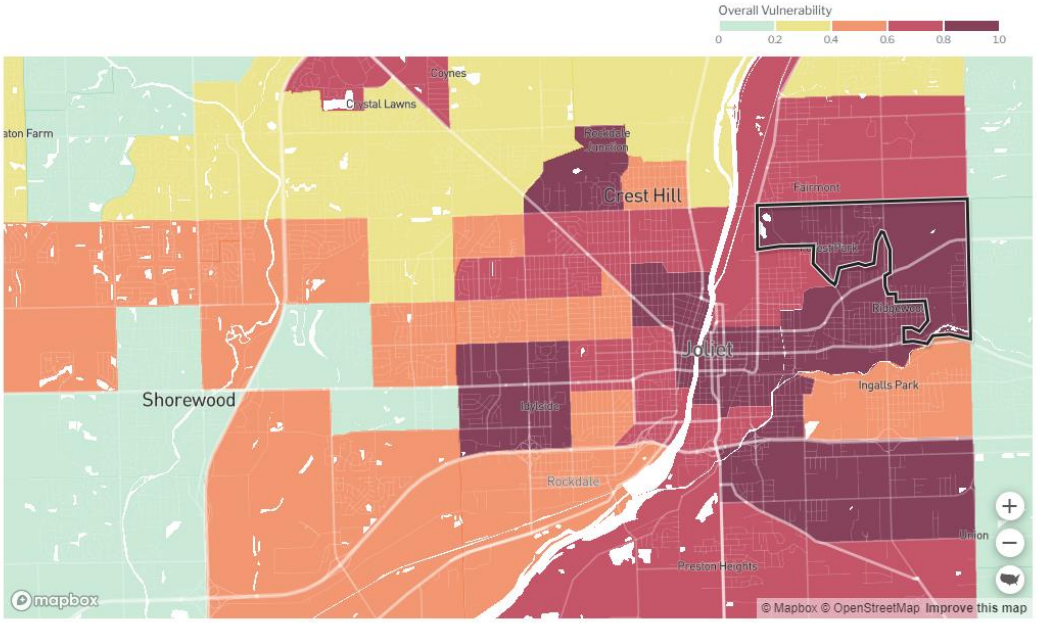
Designed & Developed by Darkhorse Analytics

Overall Vulnerability

The COVID-19 Community Vulnerability Index (CCVI), developed by Surgo Ventures, assesses how well any community in the United States could respond to the health, economic and social consequences of COVID-19 without appropriate response and additional support. It overlays indicators of social vulnerability, such as socioeconomic status or language barriers, with indicators of vulnerability unique to the COVID-19 pandemic, such as access to healthcare and comorbidities among the population. The sub-themes allow you to explore these underlying drivers of vulnerability.

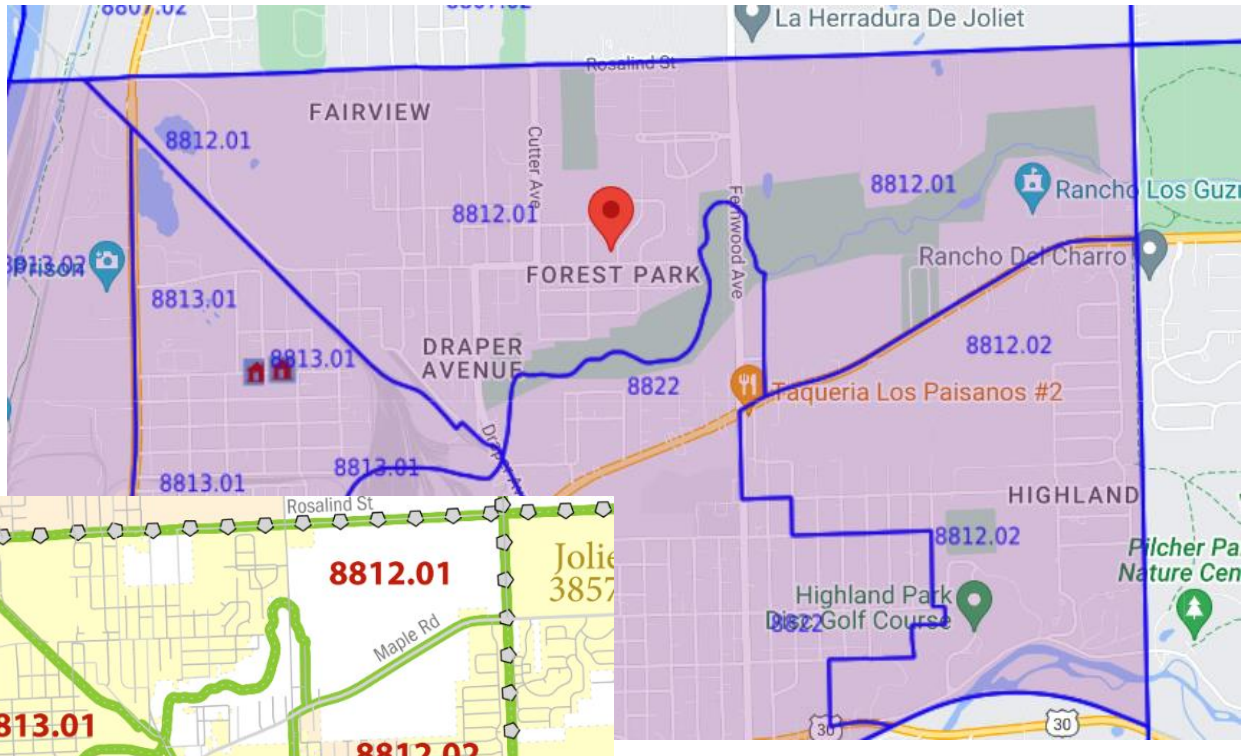
GRANULARITY: States | Counties | **Tracts**

FOCUS ON: Illinois | Will County



ONLY SHOW REGIONS WITH

Tract 8812, Will County, IL



Search for address or place...

Vulnerability

Tract 8813.01, Will County, IL

Overall Vulnerability	0.77
Socioeconomic Status	0.61
Minority Status & Language	0.98
Household & Transportation	0.63
Epidemiological Factors	0.20
Healthcare System Factors	1.00
High Risk Environments	0.10
Population Density	0.79

Race +

Elevated Health Risk (EHR) Individuals +

COVID-19 Stats +

Test Sites and Mobility +

Critical Risk Workers +

Share your findings:

For more information, contact Surgo's COVID-19 team at **covid19@surgoventures.org**

Designed & Developed by Darkhorse Analytics

Overall Vulnerability

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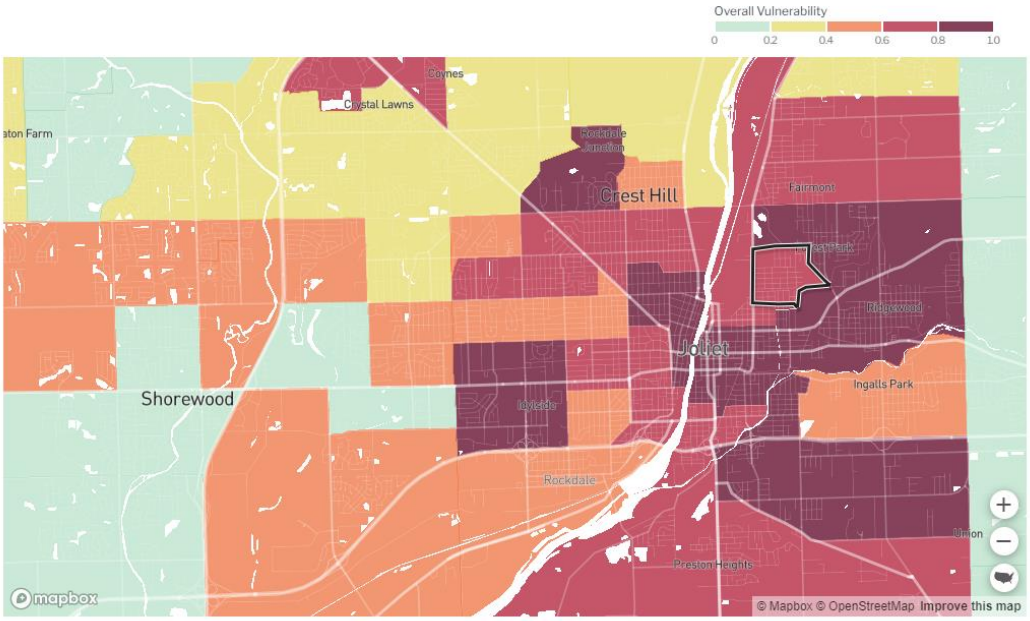
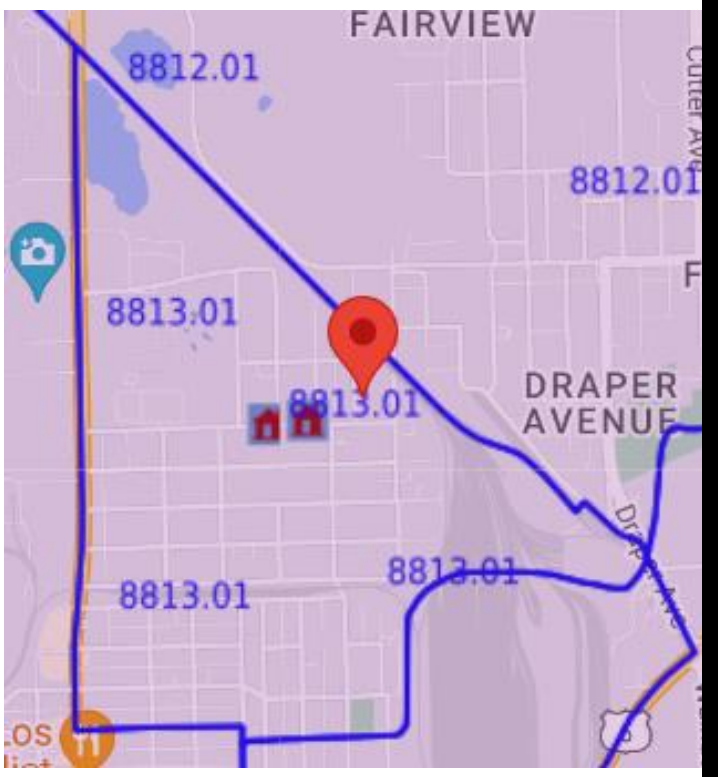
GRANULARITY: States | Counties | Tracts

FOCUS ON: Illinois | Will County



ONLY SHOW REGIONS WITH

Tract 8813.01, Will County, IL



Search for address or place...

Vulnerability

Tract 8813.02, Will County, IL

Overall Vulnerability	0.70
Socioeconomic Status	0.82
Minority Status & Language	0.98
Household & Transportation	0.52
Epidemiological Factors	0.15
Healthcare System Factors	1.00
High Risk Environments	0.10
Population Density	0.51

- Race +
- Elevated Health Risk (EHR) Individuals +
- COVID-19 Stats +
- Test Sites and Mobility +
- Critical Risk Workers +

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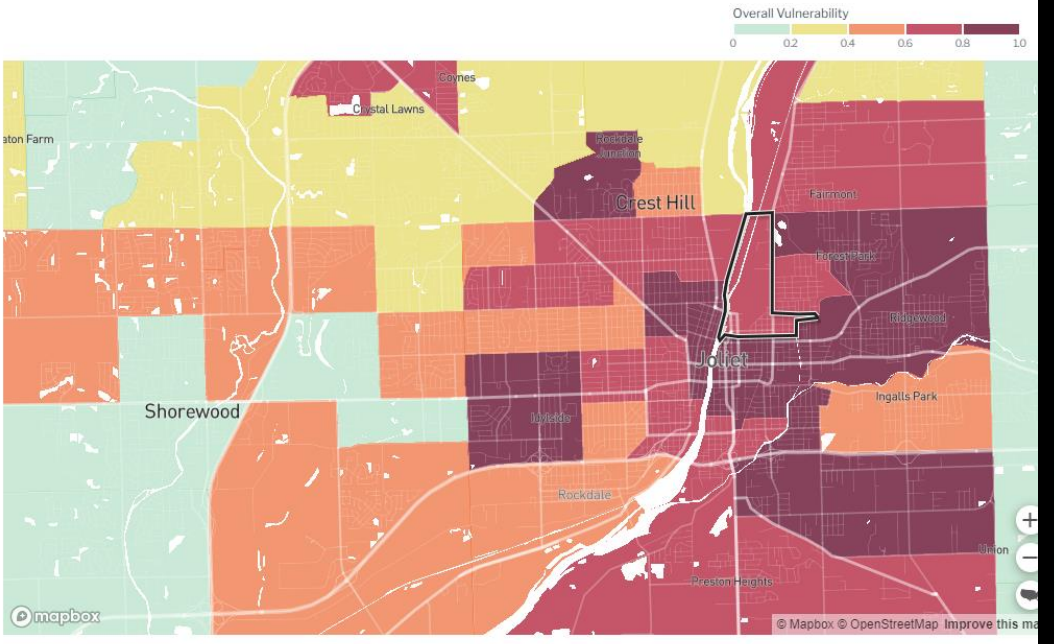
GRANULARITY: States | Counties | **Tracts**

FOCUS ON: Illinois | Will County



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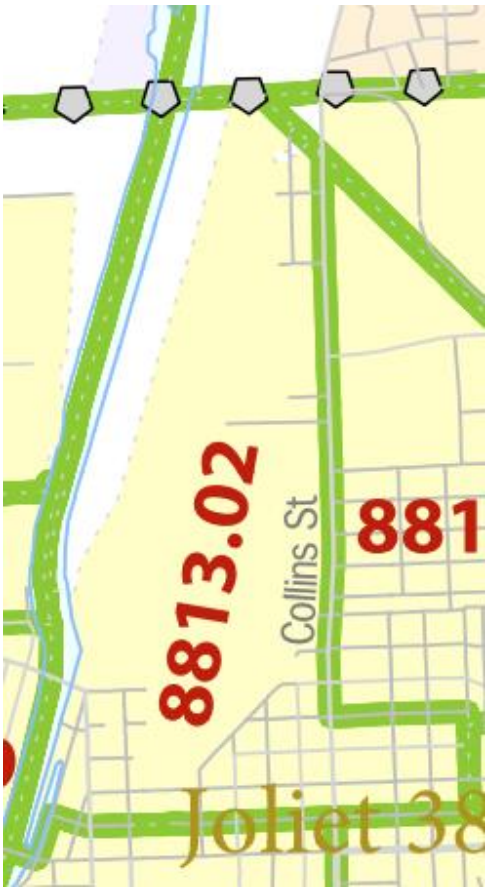

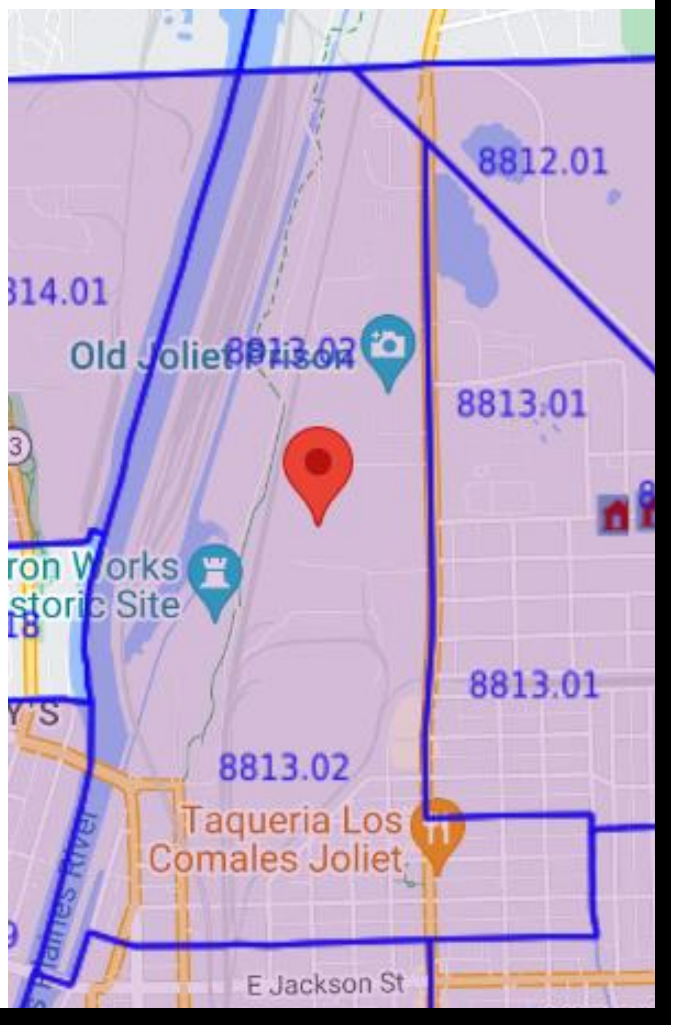

Search for address or place...

Vulnerability

Tract 8818, Will County, IL

Overall Vulnerability	0.86
Socioeconomic Status	0.87
Minority Status & Language	0.86
Household & Transportation	0.83
Epidemiological Factors	0.13
Healthcare System Factors	0.99
High Risk Environments	0.10
Population Density	0.86

Race +

Elevated Health Risk (EHR) Individuals +

COVID-19 Stats +

Test Sites and Mobility +

Critical Risk Workers +

Share your findings:

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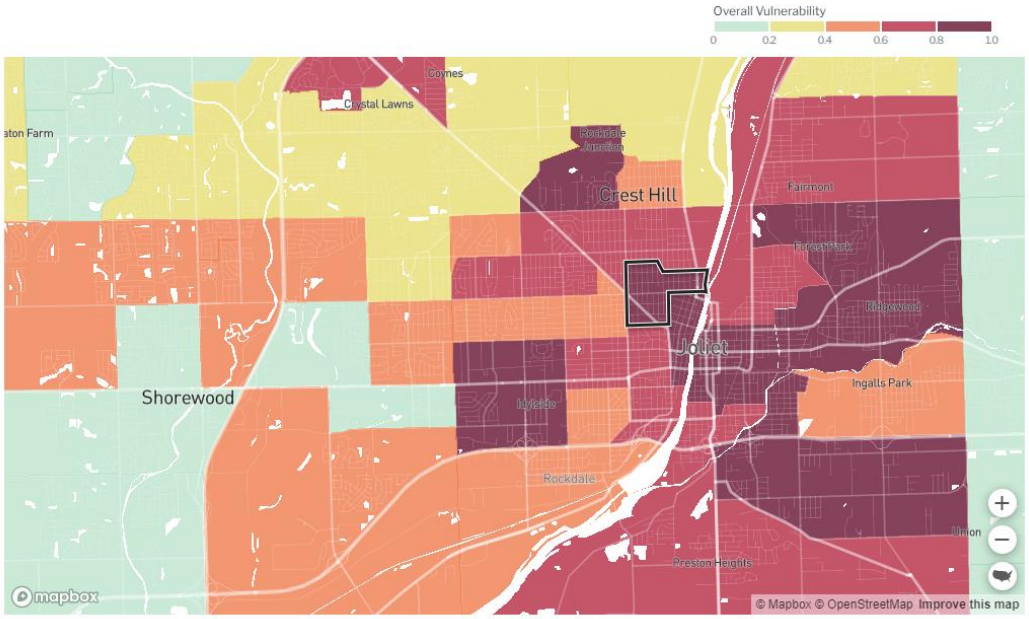
GRANULARITY: States | Counties | Tracts

FOCUS ON: Illinois | Will County



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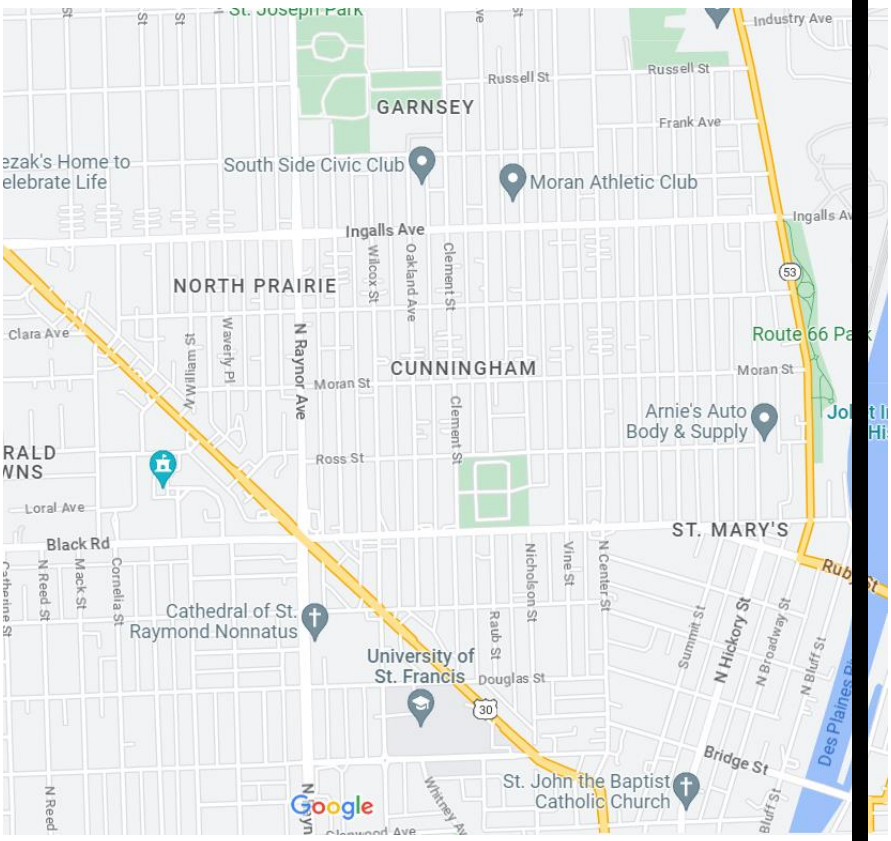
Tract 8818, Will County, IL



Search for address or place...

Vulnerability

Tract 8819, Will County, IL

Overall Vulnerability	0.94
Socioeconomic Status	0.97
Minority Status & Language	0.90
Household & Transportation	0.99
Epidemiological Factors	0.17
Healthcare System Factors	1.00
High Risk Environments	0.10
Population Density	0.90

Race +

Elevated Health Risk (EHR) Individuals +

COVID-19 Stats +

Test Sites and Mobility +

Critical Risk Workers +

Share your findings:

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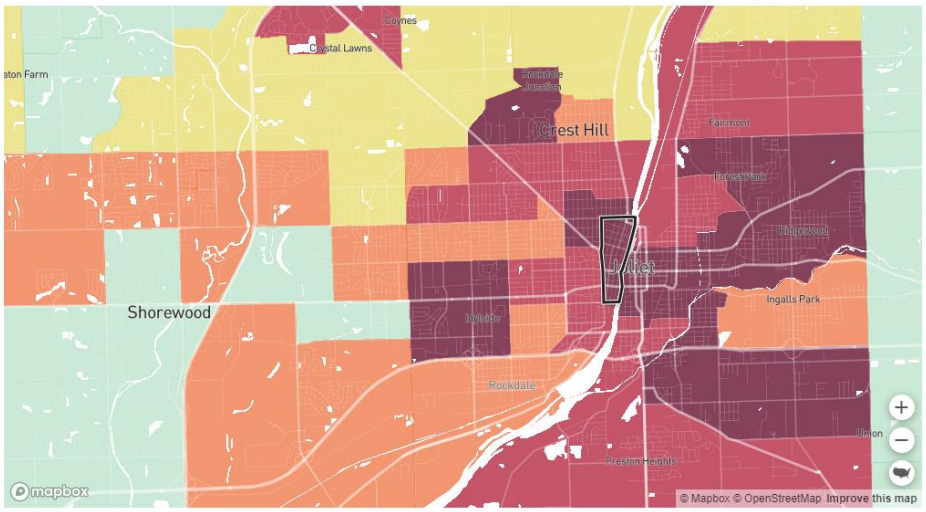
GRANULARITY: States | Counties | Tracts

FOCUS ON: Illinois | Will County

Overall Vulnerability
0 0.2 0.4 0.6 0.8 1.0



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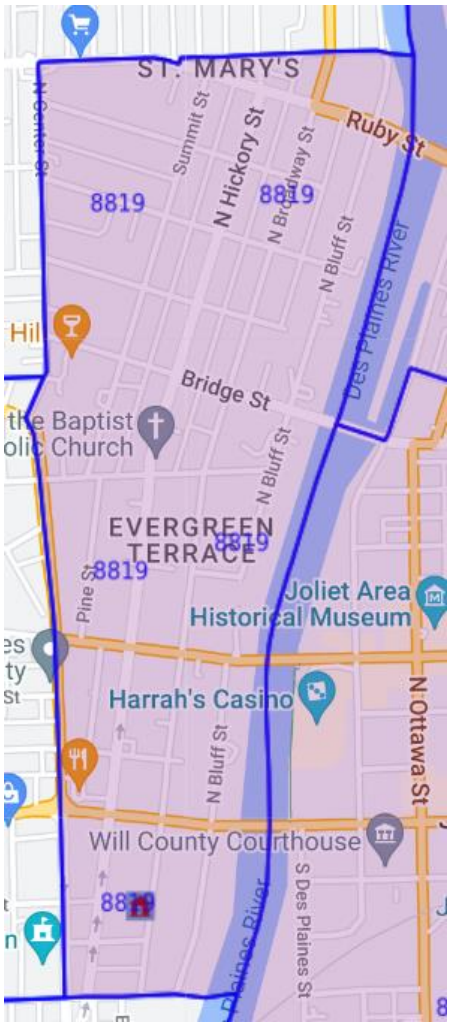

Search for address or place...

Vulnerability

Tract 8820, Will County, IL

Overall Vulnerability	0.91
Socioeconomic Status	0.94
Minority Status & Language	0.91
Household & Transportation	0.97
Epidemiological Factors	0.23
Healthcare System Factors	1.00
High Risk Environments	0.10
Population Density	0.74

Race +

Elevated Health Risk (EHR) Individuals +

COVID-19 Stats +

Test Sites and Mobility +

Critical Risk Workers +

Share your findings:

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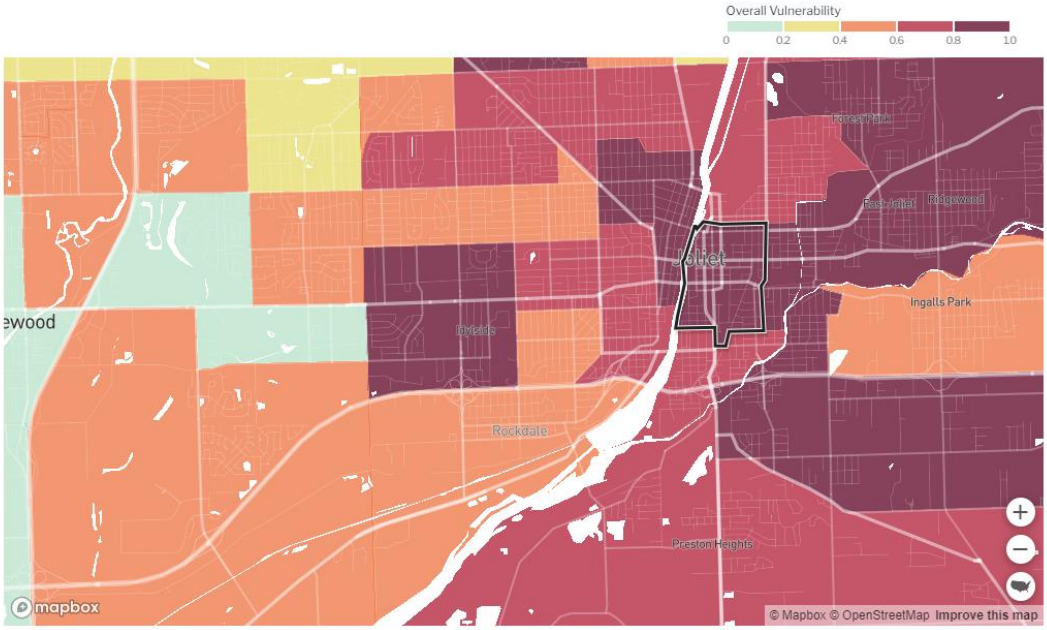
GRANULARITY: States | Counties | **Tracts**

FOCUS ON: Illinois | Will County



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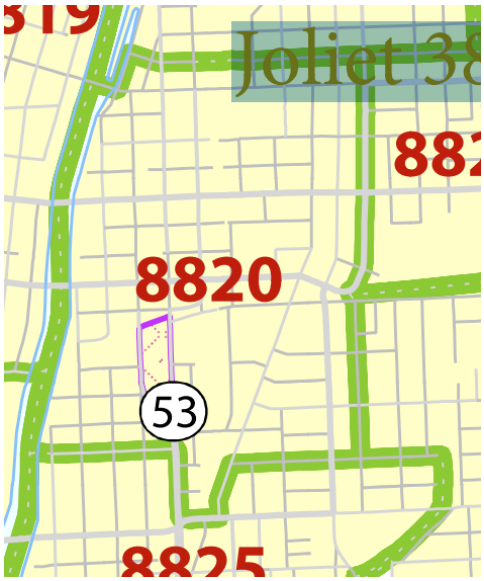
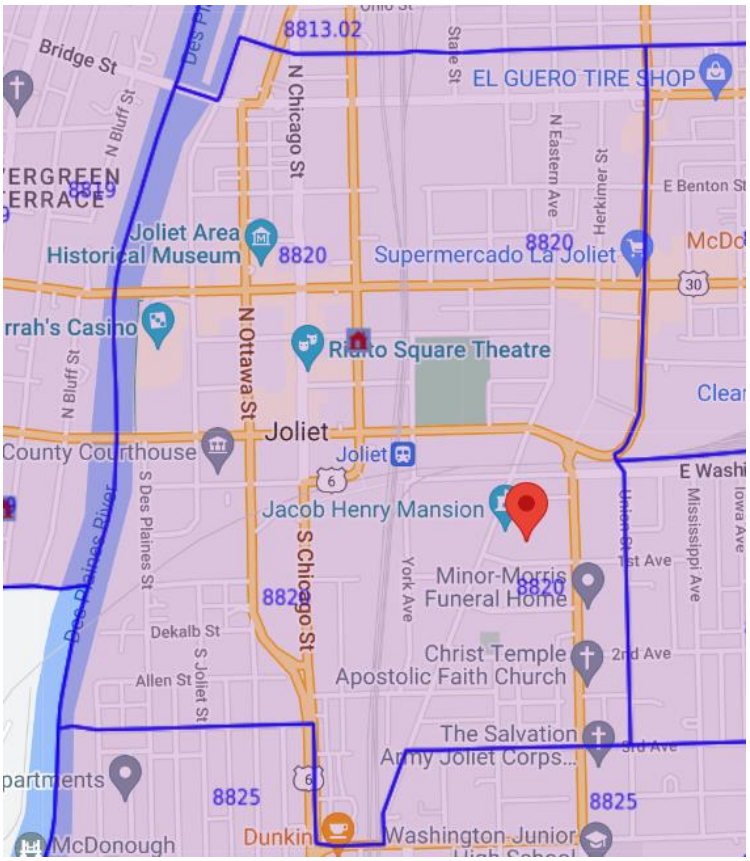
Tract 8820, Will County, IL





Search for address or place...

Vulnerability

Tract 8821, Will County, IL

Overall Vulnerability	0.90
Socioeconomic Status	0.97
Minority Status & Language	0.99
Household & Transportation	0.84
Epidemiological Factors	0.19
Healthcare System Factors	1.00
High Risk Environments	0.10
Population Density	0.74

Race +

Elevated Health Risk (EHR) Individuals +

COVID-19 Stats +

Test Sites and Mobility +

Critical Risk Workers +

Share your findings:

For more information, contact Surgo's COVID-19 team at **covid19@surgoventures.org**

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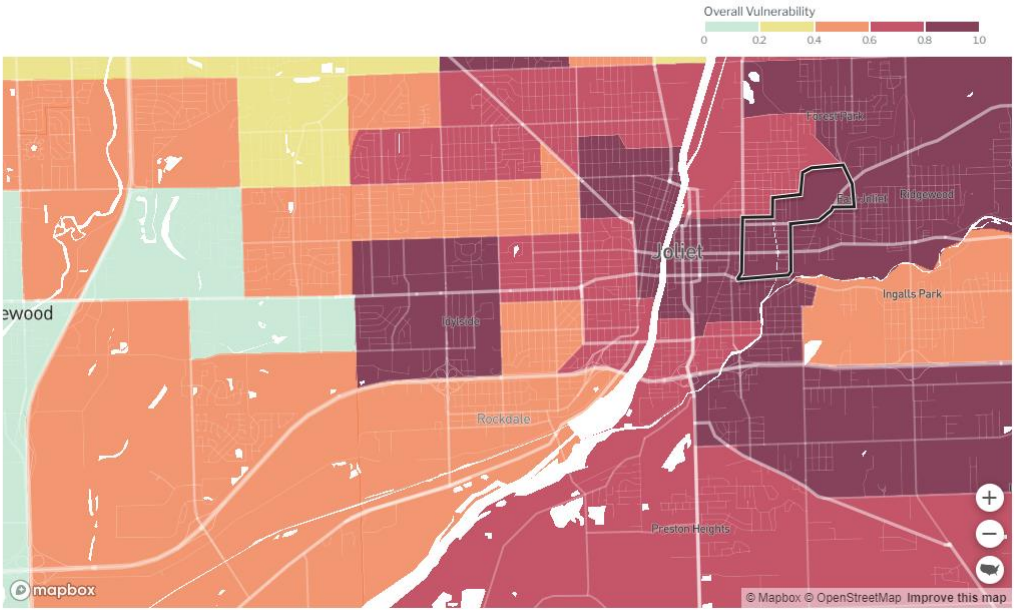
GRANULARITY: States | Counties | **Tracts**

FOCUS ON: Illinois | Will County



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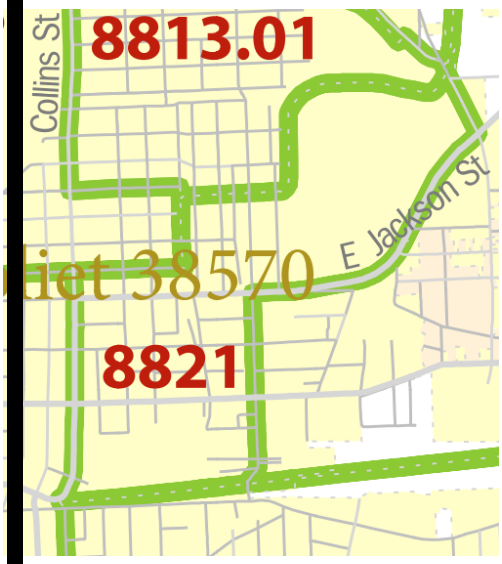
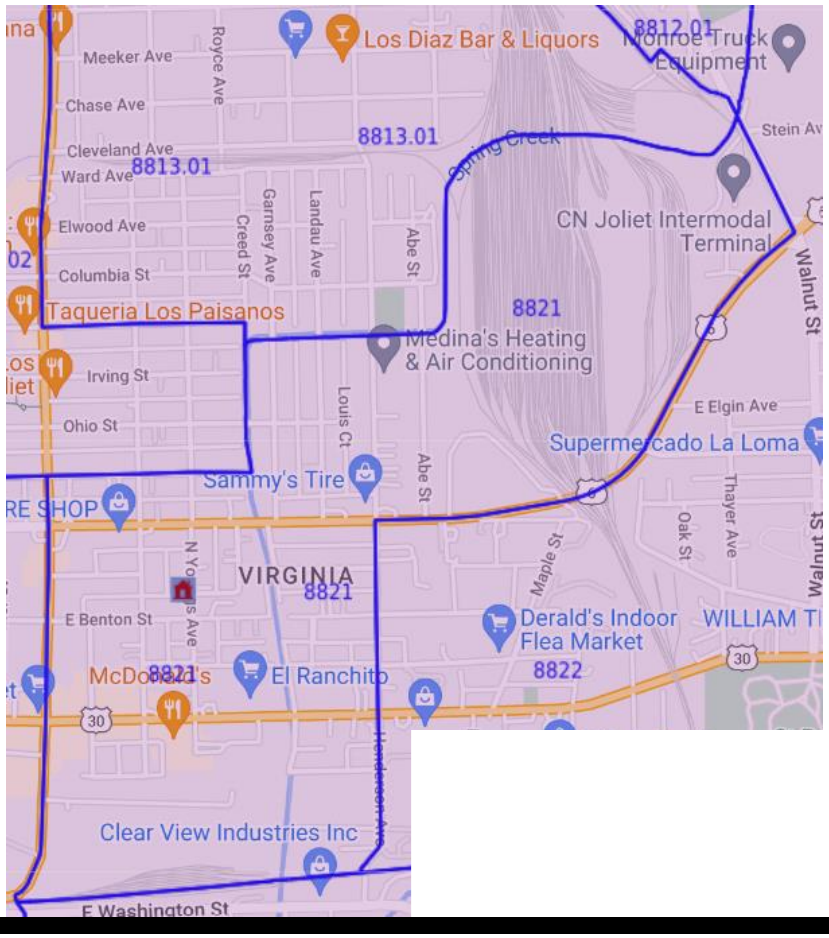
Tract 8821, Will County, IL





Search for address or place...

Vulnerability

Tract 8822, Will County, IL

Overall Vulnerability	0.93
Socioeconomic Status	0.86
Minority Status & Language	0.92
Household & Transportation	0.78
Epidemiological Factors	0.18
Healthcare System Factors	0.99
High Risk Environments	0.65
Population Density	0.58

- Race +
- Elevated Health Risk (EHR) Individuals +
- COVID-19 Stats +
- Test Sites and Mobility +
- Critical Risk Workers +

Share your findings:

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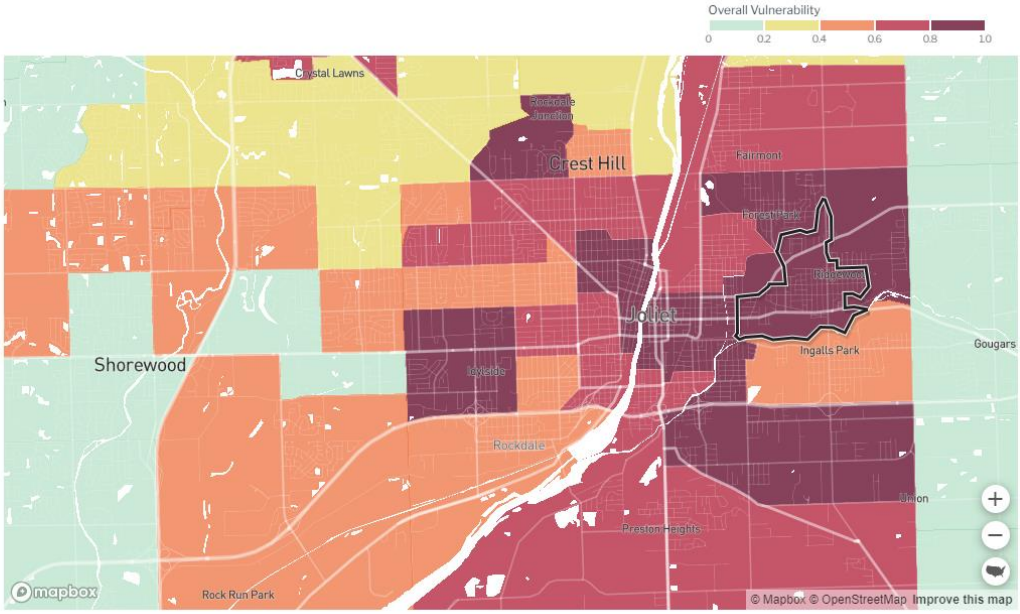
GRANULARITY: States | Counties | **Tracts**

FOCUS ON: Illinois | Will County



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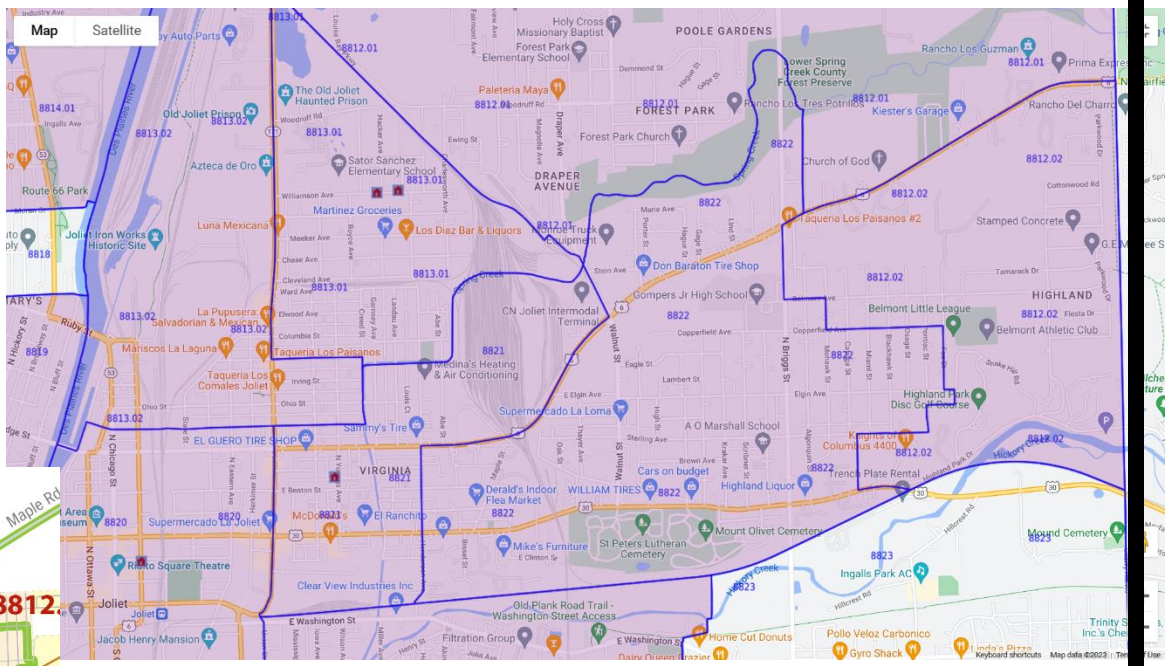

Search for address or place...

Vulnerability

Tract 8824, Will County, IL

Overall Vulnerability	0.92
Socioeconomic Status	0.96
Minority Status & Language	0.94
Household & Transportation	0.83
Epidemiological Factors	0.25
Healthcare System Factors	0.99
High Risk Environments	0.10
Population Density	0.84

Race +

Elevated Health Risk (EHR) Individuals +

COVID-19 Stats +

Test Sites and Mobility +

Critical Risk Workers +

Share your findings:

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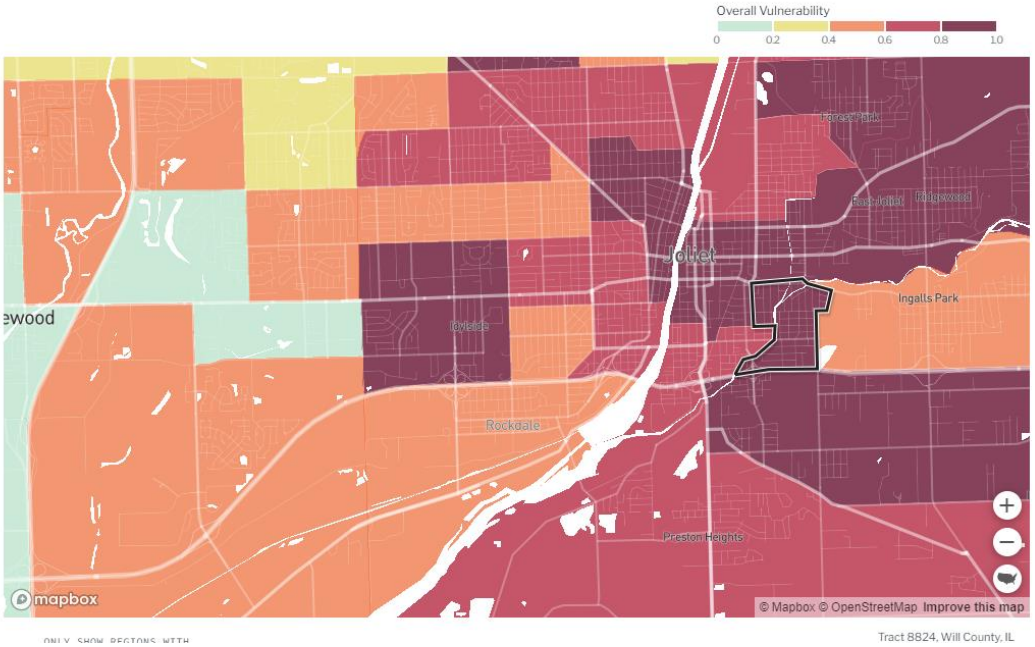
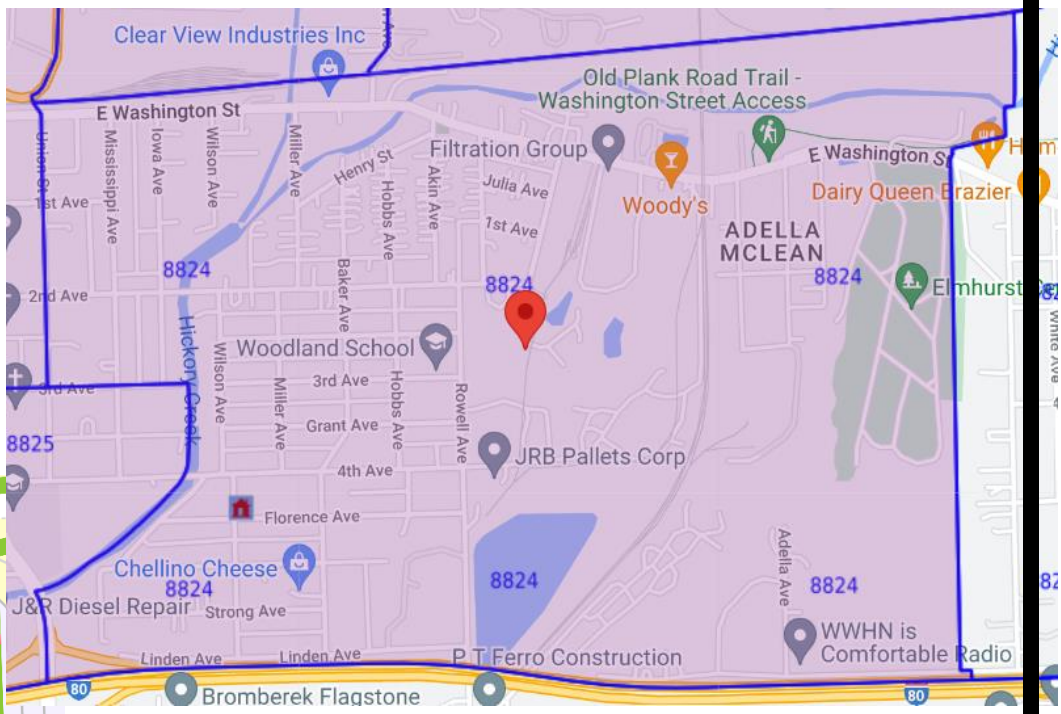
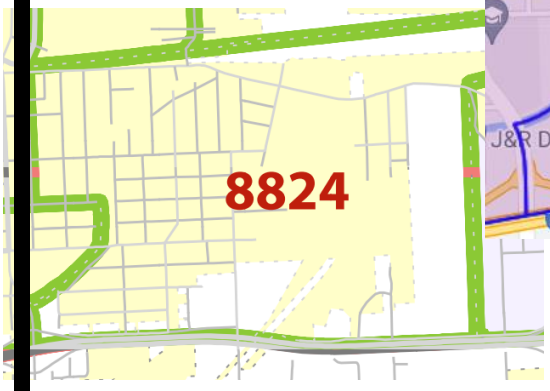
GRANULARITY: States | Counties | Tracts

FOCUS ON: Illinois | Will County



Tract 8824, Will County, IL





Search for address or place...

Vulnerability

Tract 8828.01, Will County, IL

Overall Vulnerability	0.95
Socioeconomic Status	0.55
Minority Status & Language	0.81
Household & Transportation	0.73
Epidemiological Factors	0.69
Healthcare System Factors	0.95
High Risk Environments	0.66
Population Density	0.69

Race +

Elevated Health Risk (EHR) Individuals +

COVID-19 Stats +

Test Sites and Mobility +

Critical Risk Workers +

Share your findings:

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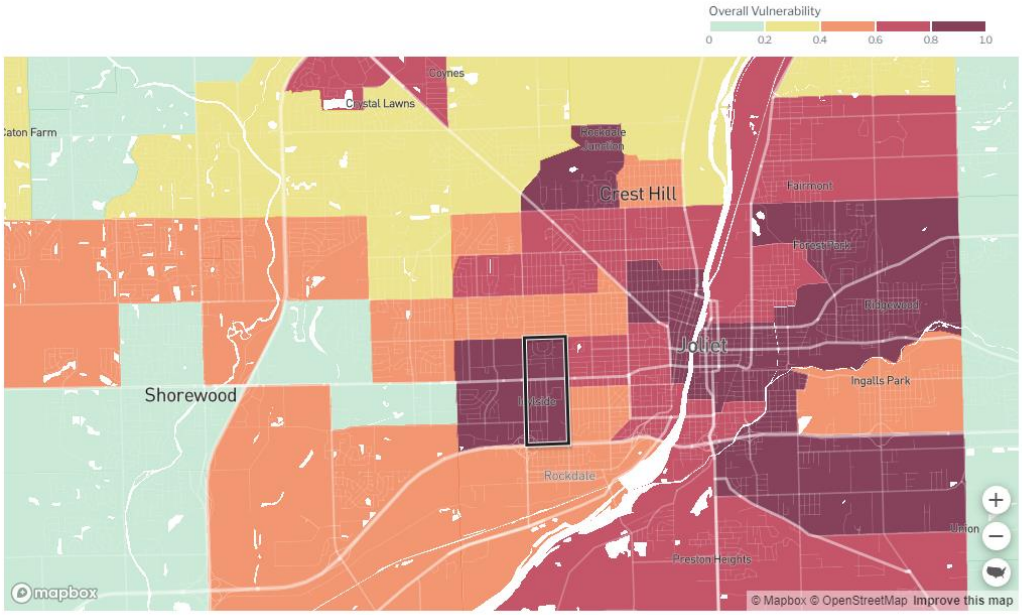
GRANULARITY: States | Counties | **Tracts**

FOCUS ON: Illinois | Will County



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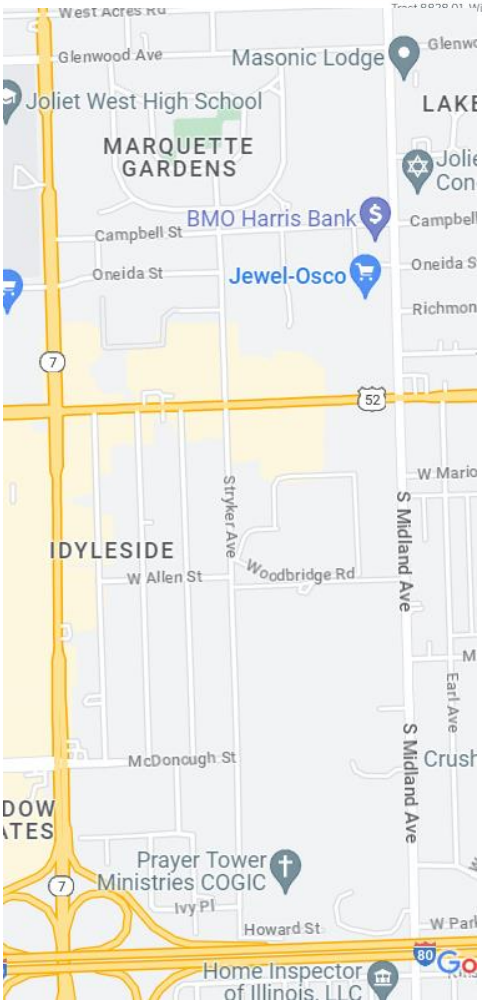

Search for address or place...

Vulnerability

Tract 8828.02, Will County, IL

Overall Vulnerability	0.99
Socioeconomic Status	0.94
Minority Status & Language	0.82
Household & Transportation	0.68
Epidemiological Factors	0.71
Healthcare System Factors	0.98
High Risk Environments	0.69
Population Density	0.60

Race +

Elevated Health Risk (EHR) Individuals +

COVID-19 Stats +

Test Sites and Mobility +

Critical Risk Workers +

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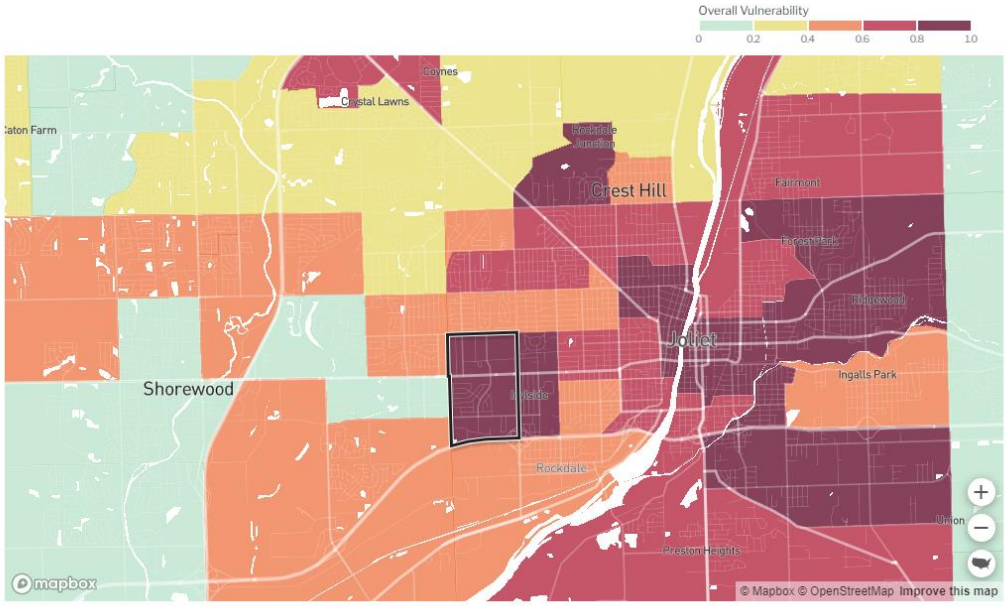
FOCUS ON: Illinois | Will County



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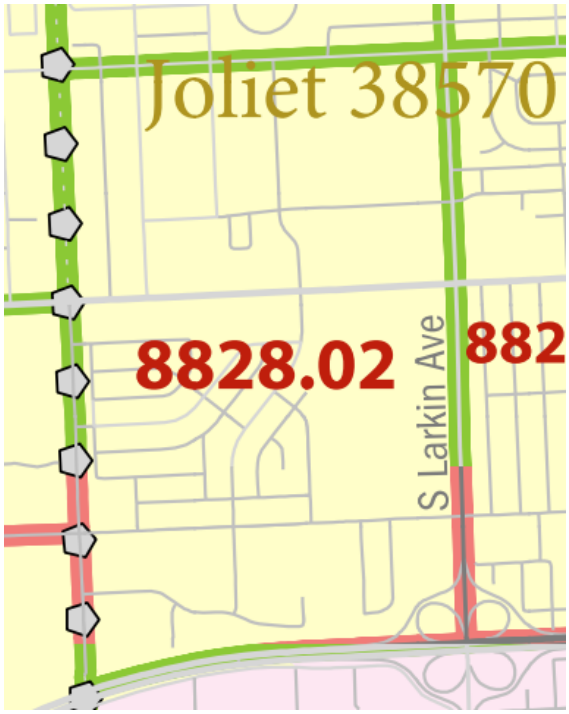
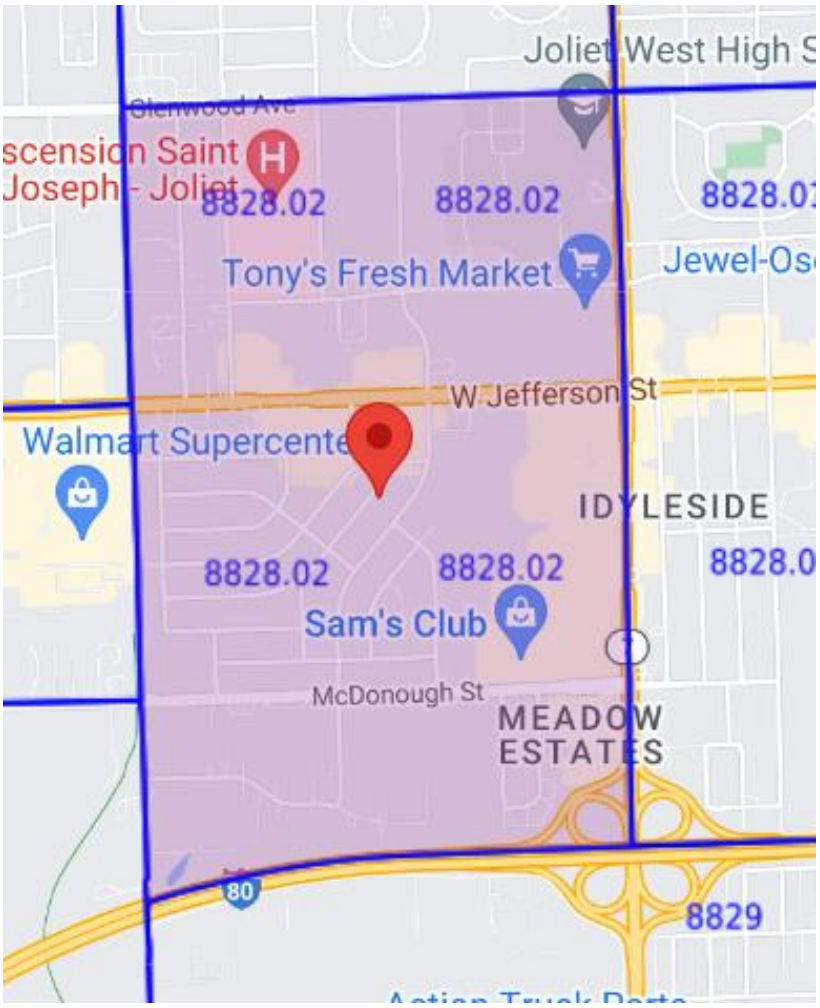
Tract 8828.02, Will County, IL





Appendix C: Letter, Application, Interview

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Community Paramedicine Team Application Request

The JFD is starting a new special team, the Community Paramedicine Team. This new grant-funded team is focused on bridging the gap between primary medical and mental healthcare providers and patients by performing home visits to evaluate patients and outreach activities to assess and educate community members.

In Phase 1, this team will focus on care for people in Qualified Census Tracts (i.e., low-income, services, transportation, and other marginalized areas). These Tracts are in Zip Codes 60432, 60433, 60435, and 60436. It includes home visits to the most disadvantaged regions of Joliet and community centers in the neediest communities.

Membership on the team requires a substantial commitment of time, energy, and a passion for helping community members. Members will be expected to achieve Board Certification as Community Paramedic, complete cultural and linguistic awareness training, work at least two 4-hour shifts per month, and participate in training as scheduled by the EMS Chief and CP Coordinator.

Interested members must be licensed paramedics for two years and submit their name to the Deputy Fire Chief by 4 PM on 11/10/2023. Those who apply will be interviewed on shift by a team assigned by the Fire Chief.

Community Paramedicine Interview Questions

Thank you for volunteering for the Community Paramedicine Team. This team is different than the other special teams in the fire department. It requires a substantial commitment of time, energy, and a passion for helping community members.

In Phase 1, this team will focus on care for people in Qualified Census Tracts (i.e., low-income, services, transportation, and other marginalized communities). These Tracts are in Zip Codes 60432, 60433, 60435, and 60436. It includes home visits to the most disadvantaged areas of Joliet.

Questions for interview:

What drew you to apply for this team?

What is your view of community paramedicine? What do you think a CP does?

Are you willing to complete the required training, including CP Board Certification and cultural competency training courses? The course is approximately 40 hours over 10 weeks of online training, and the cultural competency training is approximately 4 hours.

Do you have any special skills or expertise that make you a good candidate for this position (e.g., language skills, cultural competency, other medical skills, experience)?

Do you understand the time commitment to this group? Are you willing to put forth two 4-hour shifts per month?

Do you understand the continuing training requirements? Do you agree to be present at these sessions?

Appendix D: Intake Enrollment Form

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Joliet Fire Department Community Paramedicine
Post-Discharge
Enrollment Form

To be completed by PCP or designee.

Medical: _____ Behavioral: _____

Patient Name: _____
Address: _____
DOB: _____
Phone: _____
Email: _____
Date: _____
PCP: _____
Medical Director: _____
Diagnosis: _____
Special Instructions: _____
_____
_____

Routine visit data without unexpected findings will be forwarded to the practitioner's office. Significant changes in patient status may need to be relayed to the primary care provider immediately. The primary care provider agrees to receive the information and intervene if necessary. Changes in the patient's medications or care plan will be communicated directly to the patients and their authorized caregivers**. The EMS provider will not be authorized to take medical orders from the primary care provider.**

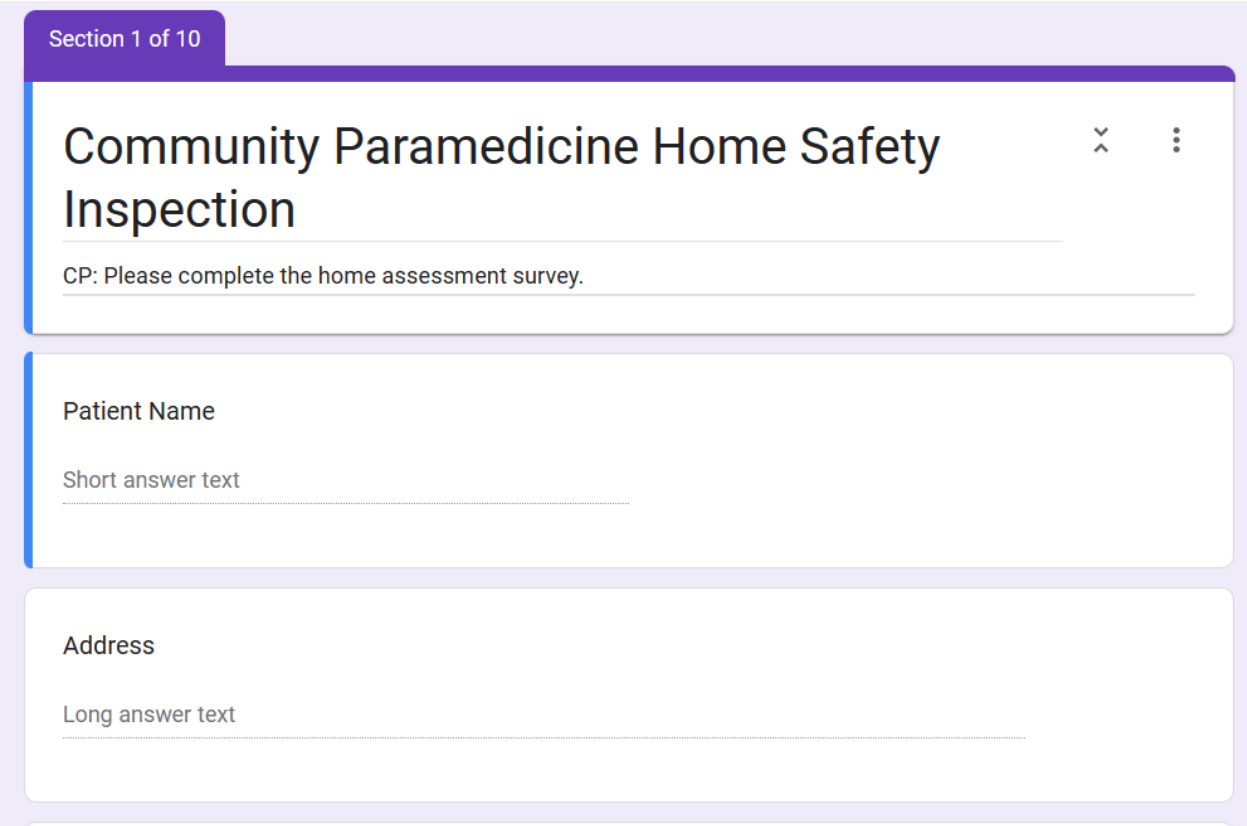
Please attach the following documents

- ☐ **Hospital Discharge Summary/Plan**
- ☐ **Discharge Medication List**
- ☐ **Other: Authorized Caregiver, POA, DNR, and other relevant documents.**

Appendix E: Home Safety Inspection

Link to the online form:

https://forms.gle/G5pUWH125XpaUtLm9



Appendix F: Patient Waiver

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WAIVER, RELEASE AND HOLD HARMLESS AGREEMENT

In consideration of the voluntary performance of a Residence Safety Assessment of my home located at _____., I, on behalf of myself, hereby waive any claim or cause of action of any nature that I have, or in the future may have, against any and all individual or organizational participants in the Residence Safety Assessment including but not limited to the _____ EMS provider and its officers, agents, or employees, which claim or cause of action grow from or results following the said Residence Safety Assessment. I further hereby agree to release and hold harmless any and all organizational and individual participants, including the aforesaid EMS provider in the Residence Safety Assessment, from and against any damages to persons or property growing out of or resulting from a Residence Safety Assessment.

I acknowledge having read, understood and agreed to the above waiver and release.

Patient (print name)	Signature	Date

POA (Legal Power of Attorney) (print name)	Signature	Date

Witness (print name)	Signature

Appendix G: Primary Care Provider Agreement

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Primary Care Provider Collaborative Agreement

JFD Community Paramedicine

This form is to be completed by primary care providers who anticipate enrolling patients in the CP Program provided by participating Emergency Medical Services (EMS) providers In their area. Participation Is voluntary for primary care providers, patients, and EMS providers. This model is designed to assist primary care providers with assessing patients with specific care plans who cannot receive traditional home healthcare services. This model is not intended to replace traditional home healthcare services.

Patients participating In the program may be referred by their local EMS agency based on EMS call patterns or by their outpatient primary care provider or Inpatient hospital and primary care provider.

Enrolled primary care providers agree to develop an outpatient care plan, communicate what assessment tool(s) will be utilized, and agree to receive information regarding their participating patients.

Once enrolled, a primary care provider may refer patients to the program. The primary care provider agrees to act within this collaborative agreement with the EMS Medical Director, who oversees the care delivered by EMS providers. The primary care provider will be able to receive the patient assessment data and make recommendations to the patient directly if appropriate. These recommendations may include care plan adjustments or recommendations to be re-evaluated.

The EMS providers will function using a pre-approved algorithm selected for the patient. Routine visit data without unexpected findings will be forwarded to the primary care provider's office. Significant changes in patient status may need to be relayed to the primary care provider Immediately; the primary care provider agrees to receive the Information and intervene if necessary. Changes in the patient's medications or care plan would be communicated directly to the patient or their authorized caregiver. The EMS **provider** will not be authorized to take medical orders from the primary care provider. The EMS provider functions using an approved algorithm.

If the EMS provider performing the patient assessment feels an emergency, the EMS Provider will begin treatment within their scope of practice and resources available, activate EMS/911, and Implement emergency care protocols. This care will fall under the EMS Medical Director and will most often result in the patient's transport to the hospital by protocol. Enrolling primary care providers must complete the following:

Name and credentials of primary care provider

_____

Signature of Primary Care Provider:

_____

Office address and phone number:

_____

Hospital Affiliation(s):

_____

Appendix H: Care Guideline: Medical

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Heart Failure Guidelines

CLINICAL INDICATORS:

A resident or patient requires non-emergency services for a heart failure assessment. Patients may be referred by:

1. Other medical providers (i.e., primary care provider, discharging hospital, home health care, or other referring agency)
2. Patient/resident request
3. EMS impression/assessment indicating that additional non-emergency services/resources may be needed.
4. At-risk referral as requested by a primary care provider.

LIMITATIONS OF ASSESSMENT GUIDELINES:

Any patient for whom an emergency exists should be treated under EMS System protocols.

PROCEDURE:

EMT-B. AEMT. EMT-I. EMT-P, PHRN

1. Introduce yourself to the patient, family and/or caregiver.
2. Identify the nature of the visit and record it in the Patient Assessment Report (why the patient requires assessment).
3. Review the patient's discharge instructions and obtain the primary care provider's name.
4. Assess for chest pain, shortness of breath, peripheral edema, other signs and symptoms, and patient's medication compliance.
5. Assess vital signs, SpO2, auscultate lung sounds, and perform a 12 Lead EKG if requested and available.
6. Weigh the patient and assess dietary compliance.

7. Review discharge instructions and assess patient compliance within the applicable scope of practice. Answer patient/caregiver questions and provide explanations if necessary. If needed, refer the patient back to the primary care provider.

8. Compare findings with the patient's discharge baseline and/or previous assessment and determine if the patient's shortness of breath or other HF signs and symptoms have worsened.

9. Document findings and communicate to the primary care provider or referring agency.

10. If a patient's condition requires action, contact the approved primary care provider/collaborator and request that the individual give instructions directly to the patient.

Post-Myocardial Infarction Guidelines

CLINICAL INDICATORS:

A resident or patient requires non-emergency services for a post-myocardial infarction assessment. Patients may be referred by:

1. Other medical providers (i.e., primary care provider, discharging hospital, home health care, or other referring agency)
2. Patient/resident request
3. EMS impression/assessment indicating that additional non-emergency services/resources may be needed
4. At-risk referral as requested by primary care provider

LIMITATIONS OF ASSESSMENT GUIDELINES:

Any patient for whom an emergency exists that should be treated under EMS System protocols

PROCEDURE:

EMT-B. AEMT. EMT-I. EMT-P. PHRN ***Refer to page 13; Requirements.**

1. Introduce yourself to the patient, family and/or caregiver.
2. Identify the nature of the visit and record it in the Patient Assessment Report (why the patient requires assessment).
3. Review the patient's discharge instructions and obtain the primary care provider's name.
4. Assess the patient's medication compliance.
5. Assess vital signs, Sp02, auscultate lung sounds, and perform a 12 Lead EKG if requested and available.
6. If Percutaneous Coronary Intervention, assess the insertion site for infection or bleeding.

7. Assess dietary and exercise compliance.

8. Assess and review lifestyle changes.

9. Review all follow-up appointments for compliance.

10. Review discharge instructions and assess patient compliance within the applicable scope of practice. Answer patient/caregiver questions and provide explanations if necessary. If needed, refer the patient back to the primary care provider.

11. Compare findings with the patient's discharge baseline and/or previous assessment and determine if symptoms have worsened.

12. Document findings and communicate with the primary care provider or referring agency.

13. If a patient's condition requires action, contact the approved primary care provider/collaborator and request that the individual give instructions directly to the patient.

Diabetes Guidelines

CLINICAL INDICATORS:

A resident or patient requires non-emergency services for a diabetic assessment. Patients may be referred by:

1. Other medical providers (i.e., primary care provider, discharging hospital, home health care, or other referring agency).
2. Patient/resident request
3. EMS impression/assessment indicating that additional non-emergency services/resources may be needed.
4. At-risk referral as requested by the primary care provider.

LIMITATIONS OF ASSESSMENT GUIDELINES:

Any patient for whom an emergency exists that should be treated under EMS System protocols.

PROCEDURE:

EMT-B. AEMT, EMT-I, EMT-P, PHRN ***Refer to page 13: Requirements.**

1. Introduce yourself to the patient, family, and/or caregiver.
2. Identify the nature of the visit and record it in the Patient Assessment Report (why the patient requires assessment).
3. Review the patient's discharge instructions and obtain the primary care provider's name.
4. Review the patient's logbook of past blood sugar readings. Note blood glucose readings trending below 60mg/di or above 250 mg/di. If trending above 250 mg/dl, perform a blood Ketone analysis if available.
5. Obtain current blood glucose levels and document findings.

6. Review the patient's diet and exercise plan.

7. Assess the patient's compliance with medications. Review current insulin dose and additional medications.

8. Assess the patient's circulation and sensory function in extremities and compare to the patient's baseline. If clinically significant changes are noted, consult a primary care provider.

9. Inspect the skin for integrity in high-risk areas. Document skin assessment.

10. Review discharge instructions and assess patient compliance within the applicable scope of practice. Answer patient/caregiver questions and provide explanations if necessary. If needed, refer the patient back to the primary care provider.

11. Compare findings with the patient's discharge baseline and /or previous assessment and determine if symptoms have worsened. If the patient's blood glucose level is below normal and the patient is alert, assist the patient with some food and/or drink. If the patient is not alert, follow the appropriate EMS System Protocol.

12. Document findings and communicate to the primary care provider or referring agency.

13. If a patient's condition requires action, contact the approved primary care provider/collaborator, and request that the individual give instructions directly to the patient.

Pneumonia Guidelines

CLINICAL INDICATORS:

A resident or patient requires non-emergency services for a pneumonia assessment. Patients may be referred by:

1. Other medical providers (i.e., primary care provider, discharging hospital, home health care, or other referring agency)
2. Patient/resident request
3. EMS impression/assessment indicating that additional non-emergency services/resources may be needed.
4. At-risk referral as requested by primary care provider.

LIMITATIONS OF ASSESSMENT GUIDELINES:

Any patient for whom an emergency exists that should be treated under EMS System protocols.

PROCEDURE:

EMT-B, AEMT, EMT-I, EMT-P, PHRN ***Refer to page13; Requirements**

1. Introduce yourself to the patient, family and/or caregiver.
2. Identify the nature of the visit and record it in the Patient Assessment Report (why the patient requires assessment).
3. Review the patient's discharge instructions and obtain the primary care provider's name.
4. Assess for shortness of breath, wheezing, and other signs and symptoms that may differ from baseline.
5. Assess for patient compliance with medications, antibiotics, and inhalers.

6. Assess vital signs, temperature, and auscultate lung sounds. Review trending of Sp02, Capnography, and peak flow as available. Document if the patient is in the red, yellow, or green zone for peak flow.

7. Review discharge instructions and assess patient compliance within the applicable scope of practice. Answer patient/caregiver questions and provide explanations if necessary. If needed, refer the patient back to the primary care provider.

8. Compare findings with the patient's discharge baseline and /or previous assessment and determine if symptoms have worsened. If the patient's wheezing has increased, assist the patient with their inhaler or home nebulizer treatment as directed in their discharge instructions and as EMS System Protocols allow.

9. Document findings and communicate to the primary care provider or referring agency.

10. If the patient's condition requires action, contact the approved primary care provider/collaborator, and request that the individual give instructions directly to the patient.

Orthopedic

A resident or patient requires non-emergency services for an orthopedic assessment. Patients may be referred by:

1. Other medical providers (i.e., primary care provider, discharging hospital, home health care, or other referring agency)
2. Patient/resident request
3. EMS impression/assessment indicating that additional non-emergency services/resources may be needed.
4. At-risk referral as requested by primary care provider.

LIMITATIONS OF ASSESSMENT GUIDELINES:

Any patient for whom an emergency exists that should be treated under EMS System protocols.

PROCEDURE:

EMT-B, AEMT. EMT-I. EMT-P. PHRN ***Refer to page 13; Requirements**

1. Introduce yourself to the patient, family and/or caregivers.
2. Identify the nature of the visit and record it in the Patient Assessment Report (why the patient requires assessment).
3. Review the patient's discharge instructions and obtain the primary care provider's name.
4. Assess vital signs. Assess the extremity for deformities, Skin, Temperature, Color, Circulation, Motor, and Sensation, and evaluate the patient's medication compliance.
5. Perform home safety inspection and verify that patient assistive devices are in good condition and easily accessible.
6. Review discharge instructions and assess patient compliance within the applicable scope of practice. Answer patient/caregiver questions and provide explanations if necessary. If needed, refer the patient back to the primary care provider.

7. Compare findings with the patient's discharge baseline and/or previous assessment and determine if symptoms have worsened.

8. Document findings and communicate to the primary care provider or referring agency.

9. If the patient's condition requires action, contact the approved primary care provider/collaborator, and request that the individual give instructions directly to the patient.

10. Inspect the incision for signs and symptoms of infection. Compare findings with the patient's discharge baseline or previous assessment and determine if symptoms have worsened; contact the primary care provider.

Appendix I: Satisfaction Survey

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Joliet Fire Department Community Paramedicine Satisfaction Survey

SURVEY INSTRUCTIONS: Please answer all questions by filling in the circle to the left of your answer.

1. When you first had your safety home visit from the paramedics, did someone talk with you about how to set up your home so you can move around safely?
   - o Yes
   - o No

2. When you started having paramedic home visits, did someone talk with you about all the prescription and over-the-counter medicines you were taking?
   - o Yes
   - o No

3. How often did the paramedics inform you when they would arrive at your home?
   - o Never
   - o Sometimes
   - o Usually
   - o Always

4. We want to know your rating of your care from the Mobile Integrated Health Program paramedic providers.

   Using any number from 0 to 10, where 0 is the worst possible and 10 is the best possible, please circle the number you would use to rate your care from the paramedic.

   0 1 2 3 4 5 6 7 8 9 10

5. Overall improvement in your well-being because of the Mobile Integrated Health Program. Circle one.

   No Improvement Slight Moderate Greatly Improved

Thank you for completing our Patient Satisfaction survey and mailing it back to Silver Cross in the enclosed postage-paid envelope.

Appendix J: Disenrollment Form

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Joliet Community Paramedicine Program: Disenrollment Form

Patient Name: _____

Patient Address: _____

Patient Phone Number: _____

CP Name: _____

Reasons(s) for Disenrollment:

- ☐ Missed Appointments
- ☐ Non-compliance with the Plan of Care
- ☐ Other (Explain)

Narrative

_____

_____

_____

_____

_____

Patient Comment

_____

_____

_____

_____

_____

CP Signature: _____

Patient Signature: _____

Appendix I: Hospital Roles

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Medical patients diagnosed with diabetes, heart failure, myocardial infarction, pneumonia, and orthopedic surgical procedures (knee replacement, hip replacement) will be offered enrollment in the Joliet Fire Department (JFD) Community Paramedicine Program (CPP) before their discharge.

Behavioral patients diagnosed with diabetes, heart failure, myocardial infarction, pneumonia, and orthopedic surgical procedures (knee replacement, hip replacement) will be offered enrollment in the Joliet Fire Department (JFD) Community Paramedicine Program (CPP) before their discharge.

For this reason, a member of hospital staff must be assigned through mutual agreement to inform the JFD Community Paramedic of admitted patients with those conditions.