FOURTH DRAFT

FIRST EDITION ACCREDITATION STANDARDS

FOR

COMMUNITY PARAMEDICINE PROGRAMS

of the

Commission on Accreditation of Medical Transport Systems

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This is the fourth draft of the 1st Edition of the
Community Paramedicine Program Accreditation Standards
for public comment. To submit comments, suggestions or to recommend changes go to camts.org or go directly to https://www.emailmeform.com/builder/form/as4HdARv5hwlo.

The standards are as appropriate to the state of residence and the specific regulator of that state as referenced by the term "Authority Having Jurisdiction" (AHJ). CAMTS Accreditation Standards, as a measure of quality, are part of a voluntary process and frequently exceed the AHJ's regulations.

CM 01.00.00 – MANAGEMENT AND STAFFING

CM 01.00.00 MISSION STATEMENT AND SCOPE OF CARE

CM 01.01.01 There is a Mission Statement written in the present tense that describes the purpose of the service, types of services provided and its constituents. The Mission Statement directs employees toward the values the service was founded upon.

CM 01.01.02 There is a written scope of service that describes the types of patients accepted (Scope of Care), services provided and exceptions (service that is not provided). Scope of Service includes range of services, procedures performed, response time, staffing configuration(s)**,** and any exceptions to types of requests that are accepted. In addition, the scope of services should be defined considering:

1. Improving patient outcomes
2. Reducing individual and health care system costs
3. Reducing hospital admissions and readmissions
4. Improving patient access to care
5. Improving health care system capacity
6. Improving health equity
7. Meeting community needs and expectations
8. Addressing resource availability
9. Building a healthy community
10. Prevention and focus on health
11. Assuring financial stability of the program

The Scope of Care is commensurate with the qualifications and level of initial and ongoing education required for medical practitioners. The Scope of Care should address, as applicable to the program, patient populations served, age groups and their definition.

> Note: The term "patient" is used throughout the standards. Programs may not see all participants in their Community Paramedicine Program as "patients" and may refer to them as participants, members or other terms. For purposes of the Standards, these terms are interchangeable.

CM 01.01.03 There is a comprehensive inventory that identifies the availability and distribution of current capabilities and resources for a variety of partners and organizations throughout the community

Examples of evidence to meet compliance:
The Mission Statement describes what you do in a clear and concise manner. The vision and mission are strategic statements developed by and unique to each organization. Values statements are separate but key underpinnings of these statements. The community-wide resource assessment documents the resources available in the local community to help meet the clinical, behavioral and social needs of patients that may be enrolled in the community paramedicine program.

CM 01.02.00 FINANCIAL COMMITMENT

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CM 01.02.01 There must be evidence of financial commitment to the program by the administrative structure and through financial resources that provide excellence in patient care and safety.

Examples of evidence to meet compliance:
Vehicles or care sites are well kept – equipment and supplies are well maintained, accessible and adequate for the patient population(s)/volume. Physical administrative surroundings are well maintained. There are adequate management and staff personnel for patient volume. Education appropriate to the scope of care and to all aspects of the organization (communications, practitioners, etc.) is provided.

CM 01.02.02 Insurance – The community medical service must have and maintain insurance against loss or damage of the kinds customarily insured against and in such types and amounts as are customarily carried under similar circumstances by similar businesses. The insurers must be financially sound and reputable, and they must be qualified to do business in the state(s) in which the service is located.

The types of insurance must include but are not limited to the following:

1.. Auto insurance (for ground vehicles owned by the service) – $1 million (U.S. dollars) and includes accidental death and disability

2. Medical Professional Liability – $1 million (U.S. dollars)

3. Worker's compensation or employer's liability – per state or equivalent government guidelines

4. Group life insurance or accidental death and disability – whether paid for by the employer or employee. A minimal coverage of one times the annual salary is encouraged.

CM 01.03.00 MARKETING AND EDUCATION FOR THE PUBLIC

CM 01.03.01 There is a stakeholder's users' group that provides guidance and consultation on operations and policies relative to the communities served. This group may include (and not limited to):

1. Clinical providers
2. Social Services
3. Public Health
4. Public Safety – Police, Fire, EMS
5. Pharmacy
6. Mental Health
7. Housing organizations/agencies
8. Suppliers (durable medical equipment, gases, medications, etc.)
9. Community leaders
10. Clergy
11. Emergency Management
12. Interrupter Services (foreign language, sign, etc.)
13. Patients and/or patient advocates
14. Hospitals and healthcare systems

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15. Third party payers (State Medicaid, insurance companies, etc.)

CM 01.03.02 There is a professional and community education program and/or printed information with the target audience to be defined by the community medical service.

1. Clear identification of the sponsoring agency(s).

2. Website information and printed materials are accurate and consistent with program documents, practice and capabilities.

3. Evidence of state licensure (or authority having jurisdiction (AHJ)) is provided for each vehicle and care site as appropriate to state or local guidelines.

4. State or local license (or AHJ) for each vehicle and care site are accessible to the public.

5. Hours of operation, phone number, and access procedure are accessible to the public.

6. Capabilities of medical practitioners--including current scope of care, a list of types of patients who are accepted based on personnel training, and configuration and equipment capabilities--are included.

7. Coverage area for the service is specified.

8. Access requirements to the service are outlined.

9. Patients considered appropriate for service are specified.

Examples of evidence to meet compliance:
Marketing materials are up to date, consistent with mission and scope, depict actual types of services and service area and do not exaggerate the scope of care or capabilities.

CM 01.03.03 There is an annual report provided to the members of the stakeholder's users' group and available to the public that outlines the number of patients served, number of visits, cost of the program, estimated patient and health systems financial cost reduction, patient outcomes, major program changes and overall impact on improving the community served.

CM 01.04.00 ETHICAL BUSINESS PRACTICES

CM 01.04.01 The service develops and demonstrates use of a written code of ethical conduct in all areas of business that demonstrate ethical practices in business, marketing and professional conduct.

1. The code of conduct guides the service when confronted with potential compliance or ethical issues.

2. The code of conduct outlines the service's standards for ethical behavior as well as contact information and reporting protocols if a standard has been violated.

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3. The code of conduct outlines ethical billing practices.

4. Upon request, for elective and/or non-emergent care or services, the program provides the patient, patient family member or third-party payor with a timely written, honest best estimate of the total cost of services.

5. There is a policy that addresses privacy rights in regard to photographing and the use of photos or other media that includes prohibiting photos placed in social media that would compromise HIPAA requirements without a patient's written permission.

Examples of evidence to meet compliance:
Policies may address such issues as proper/improper behavior toward other programs' marketing materials, honesty in reporting data, personal cell phone use, use of social media sites, how ethical issues are addressed, conflicts of interest, phone etiquette, acceptable and unacceptable behaviors on the worksite, acceptance of gifts from patients/vendors, etc.

CM 01.04.02 The Board of Directors, administrative and management staff are encouraged to complete an annual conflict-of-interest statement or form, disclosing any actual or potential conflicts.

CM 01.04.03 Ethical business practices must be maintained in policy and practice and include specific guidelines for service requests that are not performed directly by the CAMTS-accredited service or service seeking accreditation as follows:

1. Referring service requests – Referring is defined as transferring the service request to another program or service. There is no further involvement on the part of the original services, and there is no monetary exchange for the referral.

2. Subcontracted service requests – Subcontracted is defined as the occasion when another service is used to supply a portion of the care, such as testing, mental health, physical therapy, or the medical team, if the service's medical team is not available or is not appropriate.

3. Outsourcing service requests – Outsourcing is defined as transferring a request to another service but retaining control of the coordination throughout the patient care (which may include testing, mental health, physical therapy, etc.) The service may add a fee for coordinating the care, but full disclosure of the name of both the medical provider and the medical care provider employer must be made to the patient, his/her advocate and the payer source(s).

4. Brokering service requests – Brokering is defined as arranging for services and collecting a fee but not actually performing any patient care. This is not an acceptable practice of an accredited service. If the accredited service or service seeking accreditation cannot fulfill a request for services, the service may elect to subcontract or refer the request.

5. Communications if unable to provide service – The program will notify the requesting/referring agency, at the earliest possible time, when it discovers services cannot be completed. If the request for service is referred, subcontracted or outsourced the requesting/referring agency will be notified of the name and contact information of the program providing service..

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CM 01.04.04 The community medical service will know the capabilities and resources of area receiving facilities and will arrange for transport of patients, when necessary, to appropriate facilities within the service region based on patient preference, medical protocols, direct referral, approved EMS plan, or services available when no direction is provided.

1. Contractual relationships with public services or health care agencies do not reflect implied referrals.

2. Subscription services do not reflect implied referrals that could negatively impact expeditious transport of patients to the most appropriate facility.

Examples of evidence to meet compliance:
Contracts do not exceed current market value for goods and/or services or severely discount current market value with the intent to influence requests or referral patterns.

CM 01.04.05 All patient care resources, including personnel and equipment, necessary to the program's mission must be readily available and must be operational prior to initiating a patient encounter.

CM 01.05.00 COMPLIANCE

There is a corporate compliance officer or designated person responsible for ensuring that the service is following external laws and regulations, payer requirements and internal policies and procedures.

CM 01.05.01 Compliance issues may include but are not limited to:

1. Health Insurance Portability and Accountability Act (HIPAA)*

    a. If a program is using a form of telemedicine/telehealth, there are policies and procedures that outline how patient privacy issues are protected.

2. Federal civil statutes (False Claim Act)*

3. Balanced Budget Act of 1997*

4. Office of Inspector General (OIG) Compliance Program Guidance*

5. OIG annual work plans *

6. Anti-kickback and Stark laws*

7. Emergency Medical Treatment and Active Labor Act (EMTALA)*

8. Red Flag Rules (Identity Theft Prevention Program) *

9. Federal sentencing guidelines

10. Or applicable national regulations

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** (See References)*

CM 01.05.02 The compliance program includes:

1. Written policies and procedures

2. Designation of a compliance officer or assignment of responsibility to a specific individual or individuals

3. Effective training and education for staff that documents both initial and continuing competency

4. A process that allows and encourages staff to report competency concerns without fear of retaliation.

5. Effective lines of communication

6. Enforced standards based on published disciplinary guidelines

7. Auditing and monitoring

8. Procedures for responding to detected offenses and taking corrective action

CM 01.05.03 The program provides timely reporting on requested data to the state(s), or other agencies, in which it responds.

CM 01.05.04 When appropriate, the program actively participates as an integrated part of the state(s) EMS system in which it responds.

CM 01.05.05 The program integrates with external regional healthcare stakeholders to assess the overall program effectiveness. A formal assessment and recommendation report is completed at least every two years.

Examples of evidence to meet compliance:
Staff is knowledgeable about current compliance issues.

CM 01.06.00 MANAGEMENT/POLICIES

CM 01.06.01 There is a well-defined line of authority.

1. There is a clear reporting mechanism to upper-level management. An organizational chart defines how the community medical service fits into the governing/sponsoring institution, agency or corporation.

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2. For public or private institutions and agencies that contract with a community medical service, there must be a policy that specifies the lines of authority between the medical management team and the public or private institutions' management team.

3. All personnel understand the chain of command.

4. Managers are oriented to community medical standards and state regulations or AHJ pertinent to community medical services.

5. Managers are trained to recognize real and perceived pressures that may influence unsafe acts by staff.

6. The program adheres to state, national and/or local community paramedicine rules and regulations, including licensure requirements.

7. A policy must be in place that documents the employer's disciplinary process and protects employees from capricious actions.

8. There is a policy that addresses DNR orders.

9. There is a policy that addresses transfer and security of patient's personal property.

10. There is a comprehensive directory of regional patient care and service resources.

11. Management:

a. Demonstrates strategic planning that aligns with the mission, values and vision of the service.

b. Sets written guidelines for press-related issues and marketing activities.

c. Sets an Emergency Response Plan that includes a Post Accident/Incident Plan (PAIP) and responses to unexpected occurrences involving practitioners, vehicles and facilities as appropriate to the base of operations.

Examples of evidence to meet compliance:
Business plans demonstrate a needs and risk assessment when expanding the service or adding sites, and those plans include staffing, training and management restructuring for added responsibilities.

Examples of evidence to exceed compliance:
Management is educated to Just Culture and applies Just Culture principles throughout the organization.

CM 01.06.02 Employment Policies

1. A policy addresses pre-hire background checks that include, at a minimum, criminal background, license verification, and previous employer.

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2. A policy addresses annual driving record checks and license verifications.

3. A policy requires staff to self-report any investigation, arrests, or convictions.

4. A policy addresses pre-hire (whether or not it is required) drug screening.

5. A policy addresses criteria to require “for cause” drug screening.

6. A policy addresses a procedure for employee terminations that ensures protection of program information, physical and electronic data, property, and security. This may include securing the individual’s badge/keys/other access devices, deactivating e-mail accounts/computer sign-ons/remote access/codes, remaining with employee until leaving the premises, inspecting items employee takes with him or her, providing prompt notification of relevant departments/vendors/contractors and patients, procuring property that belongs to the program that the employee may have off site, etc.

CM 01.06.03 Policy Manual (electronic or hard copy) is available and familiar to all personnel

1. Operational policies must reflect current practice and are reviewed on a biennial basis as verified by dated manager’s signature on a cover sheet or on respective policies.

Examples of evidence to meet compliance:
Policies can be broken out by department/division; however, there must be signatures and revision dates on each specific policy or a cover sheet that represents biannual review with respective review dates and signatures.

CM 01.06.04 Programs are encouraged to develop a plan for succession and unanticipated extended absence for key positions. The plan should address position vacancies, including when there is no incumbent to provide transition training, as well as unplanned extended temporary absences, designed to preserve the integrity of the program.

Examples of evidence to meet compliance:
This may include cross-training, identification of successors with support of formal and informal education, mentorship, opportunities to participate in projects/presentations/events in the future role, scenarios/case studies, shadowing, job expansion, mechanisms to preserve and provide access to needed information/documents, contacts lists, task lists, detailed instruction on processes that are critical/known only to the position and periodic review/updating of the plan’s references.

CM 01.07.00 STAFFING

The service must have written operational policies to address each of the areas listed below:

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CM 01.07.01 Scheduling and individual work schedules demonstrate strategies to minimize duty-time fatigue, length of shift, number of shifts per week and day-to-night rotation. (See References for circadian rhythm, Fatigue Risk Management System (FRMS) and other fatigue studies.)

1. Medical practitioners must have the right to call "time out" and be granted a reasonable rest period if the team member (or fellow team member) determines that he or she is unfit or unsafe to continue duty, no matter what the shift length. There must be no adverse personnel action or undue pressure to continue in this circumstance.

2. Management must monitor patient care volumes and service times and the personnel's use of a "time out" policy.

3. A written policy addresses the scheduling of on-call shifts, and that policy addresses fatigue by requiring managers to monitor duty times, by tracking QM, and by using fatigue risk management.

4. A written policy defines the number and types of medical practitioners to be sent on each patient visit. The personnel level of certification/license and training should be matched to the needs of each patient.

5. Personnel must have at least 10 hours of rest with no work-related interruptions prior to any scheduled shift of 12 hours or more or prior to any on-call shift of greater than 12 hours that is scheduled to precede or follow a scheduled on-duty 12-hour shift. The intent is to preclude back-to-back shifts with other employment**,** educational requirements or school, commercial or military flying, or significant fatigue-causing activity prior to a shift.

6. The number of consecutive shifts and day-to-night rotations must be closely monitored by management for practitioners, communication specialists, vehicle operators and maintenance personnel.

7. A written policy addresses safety and clinical competency requirements for part-time or full-time staff experiencing a low volume of service responses. The policy should assure all staff are current and competent to the level of full-time, active staff in safety and the use of clinical equipment.

Examples of evidence to meet compliance:

Management monitors fatigue in terms of staffing patterns, patient outcomes and incidents or accidents with implementation to include Just Culture.

CM 01.08.00 PHYSICAL WELL-BEING

CM 01.08.01 Physical and psychological/emotional well-being is promoted through:

1. Wellness programs that promote healthy lifestyles (e.g. balanced diet, weight control, no smoking)

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2. Resources to promote psychological and emotional well-being such as suicide prevention training, trained peer support team, employee assistance programs (strongly encouraged)

3. Evidence of an injury prevention program and ergonomic strategies to reduce employee injuries

4. Protective clothing and dress code pertinent to:

   a. A uniform, professional dress code appropriate to the area served

   b. Personnel Protective Equipment (PPE) based on the patient encounter

   c. Safe operations, which may include the following, unless specified as "required" below:

      - Sturdy footwear

      - Reflective material or striping on uniforms for night operations

      - High-visibility reflective vests or appropriate Department of Transportation (DOT)-approved clothing worn by medical practitioners in accordance with ANSI-SEA 107 standard or equivalent national standard (required for medical crews and vehicle operators responding to night scene requests)

      - Appropriate outerwear pertinent to the environment (required)

5. Infection control – dress codes address jewelry, hair and other personal items of medical personnel that may interfere with patient care. Refer to Occupational Safety and Health Administration (OSHA) standards.

6. Written policies addressing:

   a. Duty status during acute illnesses, fever, cough, etc.

   b. Duty status while taking medications that may impair performance related to safety

   c. Weight/height and/or lifting ability as specified in pre-hire requirements or job description

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<u>Examples of evidence to meet compliance:</u>
Personnel are observed following the program's dress codes and are knowledgeable about policies regarding physical well-being. Policies are consistent with current national laws and may address notification to employer requirement, written documentation requirements to continue on duty, possible alternative duty assignments if team member is restricted from duty.

CM 01.09.00 MEETINGS AND RECORDS

CM 01.09.01 Meetings

1. There are formal, periodic staff meeting for which minutes are kept on file.

2. All meeting minutes (Staff, Safety, QM, etc.) include the following:

   a. Date and time of the meeting

   b. Base identification (if multiple bases)

   c. Meeting type (Staff, Safety, QM, etc.)

   d. List of those in attendance by both name and title or function (i.e., Director, Community Health Worker, RN, Paramedic, Community Paramedic, EMT, Etc.)

   e. Name of the person presiding

   f. Discussions (versus just agenda/topic headings)

   g. Assignments and responsibilities for open issues

   h. Progress reports on open issues

   i. Clear identification that an issue has been resolved (loop closure)

3. There are defined methods, such as a staff notebook or digital mechanism, for disseminating information between meetings.

4. All meeting minutes (Staff, Safety, QM meetings, etc.) are kept on file and maintained for a minimum of three years.

> Please note that Staff, Safety, QM, UM meetings can be done separately, in combination or during the same meeting. If combined, the meeting minutes should clearly have sections identified for each.

<ins>*Examples of evidence to meet compliance:*</ins>
Meeting minutes indicate attendance and representation by all disciplines. Action items, timelines and area of responsibility are well documented and demonstrate a flow of information that indicates tracking, trending and loop closure.

CM 01.09.02 Records Management ensures that patient care records, meeting minutes, policies and procedures are stored according to hospital or agency policies, and HIPAA or privacy regulations are indicative of the individual community medical service's sensitivity to patient confidentiality in accordance with local and national standards.

1. A record of patient care is completed electronically and is used for assessment of system performance and quality of care and serves as a bi-directional exchange of patient contact

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information with others associated with the patient's medical care. This includes, but may not be limited to, Primary Care providers, case managers, social service agencies and payers.

a. A policy outlines minimal requirements based on the community medical service's scope of care.

- Reason for care/services provided
- History and trending of present illness/injury, physical exam, weight, vital signs, and pain assessments, per patient needs assessment and program's guidelines
- Diagnosis/impression
- Allergies
- Treatments and medications and patient's response to treatments, procedures, and medications. This includes an inventory of all medications (prescription and non-prescription) and a reconciliation with physician orders.
- Documentation of pertinent imaging and laboratory reports including Point of Care work.
- A care plan, with outcome goals, as outlined by the referring physician/agency or accepted by the program medical direction.
- Assessment of the patient's home environment including home safety (fall risks), health routines and living habits.
- Documentation of additional referrals to in-home support services, community resources (such as behavioral health and case management) and assistance with coordination of follow-up appointments.
- Documentation if telehealth was performed, with which provider and any orders given.
- Signature of each care provider and clarity about what care was performed by each provider(administering medications and performing procedures) and indicates who actually documented patient information
- A plan for continuity of the medical care including how records will be documented, stored and shared and to whom the report is given.

b. A patient care summary, with medication reconciliation and patient instructions, is left with the patient at the conclusion of each visit.

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c. A policy outlines approved abbreviations for use in patient care records. Medication abbreviations are avoided.

d. A policy outlines the expectations for completion of patient care records in a timely manner. (i.e. 90% completed within 24 hours)

e. A stored permanent electronic patient care record is preferred, but scanned hard copies are acceptable. Where possible, the community paramedicine medical record should be part of, and/or, uploaded to the referring hospital or physician medical record system(s).

Examples of evidence to meet compliance:
Patient records are signed and initialed by the practitioners who performed the treatment or procedure. Records are stored in a secure area that is inaccessible to the public with accessibility limited according to applicable HIPAA guidelines.

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CM 02.00.00 – COMMUNITY PARAMEDICINE QUALITY MANAGEMENT
Includes Quality, Utilization and Safety Management

CM 02.00.00 QUALITY MANAGEMENT

Management monitors and evaluates the quality and appropriateness of the community paramedicine service through an active Quality Management (QM) program, including the following:

CM 02.01.01 A QM flow chart diagram or comparable tool is developed demonstrating organizational structure in the QM plan and linkage to the Safety Management System.

CM 02.01.02 The QM plan should emphasize that the quality of services offered is considered on a continuum, with constant attention to developing new strategies for improving. Maintaining the status quo or achieving arbitrary goals are not considered the end-measures.

CM 02.01.03 The QM program should be integrated and include activities related to patient care (including customer satisfaction and employee satisfaction), communications, and all aspects of community paramedicine operations and equipment maintenance pertinent to the service's mission statement. Involvement with community partners is strongly encouraged.

CM 02.01.04 There is an ongoing Quality Management (QM) program designed to monitor, assess and improve the quality and appropriateness of patient care and safety of the community paramedicine service objectively, systematically and continuously.

CM 02.01.05 Promotes the effectiveness of the QM program through active participation by management and staff in the program and by sponsoring active communication pathways bi-directionally between staff and management.

CM 02.01.06 The QM Program is linked with risk management, so that concerns identified through the risk management program can be followed up through the continuous quality improvement program:

1. There is a written policy that outlines a process to identify, document and analyze sentinel events, adverse medical events or potentially adverse events (near misses) with specific goals to improve patient safety and/or quality of patient care.

2. There is follow-up on the results of actions /goals for specific events until loop closure is achieved.

3. The process encourages personnel to report adverse events even if it is a sole source event (only the Individual involved would know about it) without fear of punitive actions for unintentional acts.

CM 02.01.07 The community paramedicine service has established patient care guidelines/standing orders that must be reviewed annually (for content accuracy) by management, QM Committee members and the Medical Director(s).

CM 02.01.08 The Medical Director(s) is responsible for ensuring timely review of patient care

CM 02.01.09 There is an established QM program in place that includes:

1. Responsibility/assignment of accountability

2. Scope of care

3. Important aspects of care, including clinical outcomes

4. Operational processes such as financial outcomes and customer needs

5. Quality indicators (Key Performance Indicators)

6. Thresholds for evaluation appropriate to the individual service

7. Methodology - the QM process or QM tools utilized and how individual indicator scores are measured/calculated

8. Evaluation of the improvement process

9. Assuring integration of care with the patient's physicians and health care system.

CM 02.01.10 For both QM and utilization review programs, there should be evidence of actions taken in problem areas and evaluation of the effectiveness of that action.

Examples of evidence to meet compliance:

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Development of quality metrics that will allow the program to improve in their processes should be developed with indicators focusing on every aspect of the program (i.e. coordination, clinical, safety, etc.) A flow chart outlining the process flow when outliers and how the loop is closed to ensure that each outlier was addressed. Subsequent action to trends in activity should be noted with constant evaluation of the performance improvement process (i.e., Deming Cycle; Plan, Do, Study/Check, Act). The QM plan is current and describes the process with evidence of loop closure in subsequent reports.

CM 02.01.11 There will be regularly scheduled QM meetings providing a forum for all disciplines involved in the community paramedicine service to present their needs and areas for improvement to each other. Minutes will be taken and distributed to management and staff not participating in the meetings.

CM 02.01.12 The monitoring and evaluation process has the following characteristics:

1. Driven by important aspects of care and operational practices identified by the community paramedicine service's QM plan

2. Indicators and thresholds or other criteria are identified to objectively monitor the important aspects of care.

3. Evidence of QM studies and evaluation in compliance with written QM plan

4. Evidence of action plans developed when problems are identified through QM and communication of these plans to the appropriate personnel

5. Evidence of reporting QM activities through established QM organizational structure

6. Evidence of on-going re-evaluation of action plans until problem resolution occurs

7. Evidence of annual goals established prospectively for the QM program which provide direction for the work groups and which are quantitative. The emphasis must be on loop closure and resolution of problems within a finite time period.

CM 02.01.13 Quarterly review should include at a minimum, but may exceed, criteria based upon the important aspects of care/service. The following examples are encouraged:

1. QM personnel may collect data and refer to the Safety Committee for action and resolution.

2. Operational criteria to include at a minimum the following quantity indicators:

   a. Number of completed service visits.
   b. Number of aborted and canceled service visits (defined as departed but never completed the visit) (i.e.: patient not home, patient refused to be seen, diverted to another location, etc.)
   c. Number of missed services visits and reasons missed (defined as unable to accept the service request) (i.e.: lack of staff, system capacity, lack of vehicles, etc.)
   d. Number of patient that have "graduated out" and are no longer in need of the

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program's services.

3. Service visits delays and reason.

4. Change in patient's condition that required additional interventions

5. Never events (see references)

6. Requests of additional emergency response from EMS, public safety or emergency psychiatric services.

7. Patients with known communicable disease at the time of the request or discovered after the service visit.

Examples of Evidence to Meet Compliance:
The QM plan is current and describes the process with evidence of loop closure in subsequent reports. QM does not consist only of medical record reviews.

Examples of Evidence to Meet Compliance:
Outcomes from QM should drive systems/process/procedures changes, education and training needs. Systems improvement tools are educational. The process is not directed toward an individual nor is it punitive.

Tracking and trending of the time between the referral and first encounter and times at the service locations are evaluated in terms of benchmarks set by the program in order to evaluate the effectiveness of policies/procedures, training and/or equipment needs. If services are delayed, reasons for delays are tracked as are service requests that are conducted by alternate medical service providers.

CM 02.02.00 UTILIZATION MANAGEMENT (UM)

Management ensures an appropriate utilization management process through trending and tracking requests. Utilization review may be prospective, concurrent, or retrospective.

CM 02.02.01 Management ensures an appropriate utilization management process based on:

1. Benefits to the patient (medical, psychosocial, community health)

a. Timeliness of the services as it relates to the patient's clinical status

a. Patient care needs consistent with the capabilities and limitations of the community medical service and the medical providers' skills

b. Patients' own assessment of improvement or impact in quality of life, including pain

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and discomfort, use of medications, mobility, self-care, patient's out-of-pocket medical expenses, anxiety/depression and performance of usual activities

2. Safety of the community paramedicine environment

3. A structured, periodic review of services (to determine service appropriateness, safety or cost effectiveness over other types of medical care) performed at least semiannually and recorded in a written report. This report indicates criteria have been tracked and trended and feedback was provided when there are inappropriate requests from referral and contacting agencies.

4. The following criteria trigger a review of the record to determine medical appropriateness based upon patients:

a. Who have needs not reported by the requesting agency

b. Who are served by an inappropriate provider in consideration of time, distance or speed, etc.

c. Who are served by an inappropriate team, i.e., Primary Care Provider used but patient required Advanced Care or social services or when social services referrals were made when Primary Care is the immediate need.

5. Expenditure and cost of care (by patient and in aggregate)

a. Trending of emergency medical service requests, emergency department visits, hospital and nursing facility inpatient admissions, inpatient days and physician office visits prior to and following establishment of care by the community paramedicine program.

b. Tracking and trending of patient improvement/changes including patient self-assessment of general health and pre and post intervention (blood pressures, smoking cessation, A1C, BMI, Etc.)

b. Number of program visits

c. Cost and cost avoidance of emergency department, inpatient care and physician office visits

d. Cost of program visits

e. Source of the referrals

CM 02.02.02 Management ensures that steps are taken to reduce those services that are considered to be non-appropriate.

Examples of Evidence to Meet Compliance:

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UM reports indicate trending and loop closure of patient outcomes. Requesting agents are contacted if there are trends that indicate over-triage or under-triage. Continuous review of UM with applicable trending and loop closure of patient outcomes in the form of follow-up with receiving facility, documented phone calls to patient/family, etc. may provide adequate information about patient outcome. Outliers should be presented to a QM Committee or during regularly scheduled staff meetings to discuss specifics of the service provided.

CM 02.03.00 SAFETY MANAGEMENT
(includes Safety Management Systems and Safety and Environment)

CM 02.03.01 Safety Management System - Management is responsible for a Safety Management System (SMS) but both management and staff are responsible for ensuring safe operations. The Safety Management System is proactive in identifying risks and eliminating injuries to personnel and patients and damage to equipment and includes:

1. A statement of policy commitment from the accountable executive

2. Risk identification process and risk management plan that includes a non-punitive system for employees to report hazards and safety concerns

3. A system to track, trend and mitigate errors or hazards

4. A system to track and document incident root cause analysis

5. A Safety Manual

6. A system to audit and review organizational policy and procedures, ongoing safety training for all practitioners (including managers), a system of proactive and reactive procedures to insure compliance, etc.

7. A process for dissemination of safety issues to all personnel for loop closure

8. There is evidence of management's decisive response to non-compliance in adverse safety or risk situations.

    a. Senior leadership should establish a process to identify risk escalation to ensure that safety and risk issues are addressed by the appropriate level of management up to and including the senior level.

    b. Operational Risk Assessment tools should include but not be limited to issues such as: service acceptance, public relations events, training, maintenance and re-positioning trips. For service, the tool should include:

    - Assessing fatigue
    - Clinical acuity of patient

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- Potential risks related to:
    1. Single provider services
    2. Location and environment of the area were services are provided including safety of the residences or building
    3. Other at-risk individuals at the home
    4. Communicable disease
    5. Use of marked vs unmarked vehicles
    6. Use of provider uniforms

- Foreign language considerations (does the care provider speak local language)

- Experience of medical provider

- Other temporary situations in areas traveled that may increase risk (for example, extreme weather forecasted, recent/impending political or natural disaster, etc.)

9. Policies address practitioner safety and include but are not limited to the following examples:

    a. Cultural intelligence

    b. Checking with local law enforcement regarding high risk areas.

    c. Accountability with respect to the location of the provider, in case of needing assistance (i.e. location tracking, check in etc.)

10. The program has a process to measure their safety culture by addressing:

    a. Accountability – employees are held accountable for their actions

    b. Authority – those who are responsible have the authority to assess and make changes and adjustments as necessary

    - Standards, policies and administrative control are evident

    - Written procedures are clear and followed by all

    - Training is organized, thorough and consistent according to written guidelines

    - Managers represent a positive role model promoting an atmosphere of trust and respect

    c. Professionalism – as evidenced by personal pride and contributions to the program's positive safety culture

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d. Organizational Dynamics

- Teamwork is evident between management and staff and among the different disciplines regardless of employer status as evidenced by open bi-directional and inter-disciplinary communications that are not representative of a “silo” mentality.

- Organization represents a practice of encouraging criticism and safety observations, and there is evidence of acting upon identified issues in a positive way.

- Organization values are clear to all employees and embedded in everyday practice.

11. A Safety Management System includes all disciplines and processes of the organization. A Safety Committee is organized to solicit input from each discipline and should meet at least quarterly with written reports sent to management and kept on file as dictated by policy

a. Safety issues should be identified by the Safety Committee with detailed reporting and analysis of vehicle/patient safety aircraft incidents, travel and cultural incidents that could potentially affect crew safety and resolution of issues with findings.

b. The committee will promote interaction between medical practitioners and communications personnel addressing safety practice, concerns, issues and questions.

c. There is evidence of action plans, evaluation and loop closure.

12. The Safety Committee is linked to QM and risk management

13. Vehicle related events that occur during a medical visit are identified and tracked to minimize risks. (See Glossary in Appendix for definition of event)

a. Community medical services are required to report accidents to CAMTS and must report to the appropriate government agencies as required. There is a written policy that addresses reporting incidents or accidents and assigns certain individual(s) with the responsibility to report.

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CM 02.04.00 SAFETY AND ENVIRONMENT

CM 02.04.01 Patient and personnel security

1. A policy addresses the security of the physical environment where services are to be provided.

2. A policy addresses cyber security and the protection of program and patient information.

3. Personnel security - Medical staff are required to carry program issued photo identification cards with their first and last names and identification as a community health provider. A driver's license and\or passport shall also be carried while on duty. If required but local or state law, the provider's current certification or license identification must also be carried.

4. Patient security - Patients and accompanying family/companion(s) must be properly identified and listed by name (in compliance with HIPAA regulations) in the communications/coordination center by the service coordinator.

Examples of Evidence to Meet Compliance:
Policy requires wearing or carrying ID's while on duty

CM 02.05.00 SAFETY EDUCATION

CM 02.05.01 Education Specific to Safety of the Community paramedicine Environment - Completion of all the following educational components should be documented. These components should be included in initial education as well as reviewed on an annual basis with all regularly scheduled, part-time or temporarily scheduled medical practitioners as appropriate for the mission statement and scope of practice of the service.

1. Communications strategies and back-up plans

2. Specific capabilities, limitations and safety measures

3. Survival training/techniques/equipment that is pertinent to the environment/geographic coverage area of the medical service but must include at a minimum:

    a. Safety and survival equipment requirements

    b. Confrontation de-escalation and self defense

4. General safety to be included on an annual basis.

    a. Driver training and safety if part of the medical providers responsibilities

    b. Safety around the vehicle and work sites (residences, scenes, homeless shelters, etc.)

5. General vehicle safety including:

    a. Loading/unloading equipment and supplies

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b. Seat belt use

c. Securing loose items/equipment

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CM 03.00.00 – COMMUNITY PARAMEDICINE PATIENT CARE

CM 03.01.00 MISSION TYPES AND PROFESSIONAL LICENSURE

Staffing should be commensurate with the mission statement and scope of care of the medical service and potential needs of the patient. A well-developed position description for each discipline is written. The program will have all equipment, medications, interventions and quality metrics below that are relevant to the program's mission and scope of service (which includes scope of care). Equipment, medications, interventions and quality listings in each type of care build on each other starting with Primary to ALS to Specialty Care.

CM 03.01.01 Primary Care - A Primary Care medical service is defined as the care of a patient whose condition warrants a care provider commensurate with the scope of practice of an Emergency Medical Technician or national equivalent. The focus should be on prevention of illness, improving health and choosing healthy lifestyles. The patient is stable and requires minimal care.

Preface – appropriate Authority Having Jurisdiction (AHJ) applies

1. Scope of Care – Capability to deliver out of hospital basic care

2. Clinical Practitioners

   a. The EMT provider must be licensed, certified or permitted according to the appropriate state regulations or by AHJ and has current relicensing, recertification, or re-permitting status and must have a minimum of 2 years of experience in the pre-hospital setting. National registry (NREMT) and education and certification as a Primary Care Technician and/or Community Paramedic Technician are encouraged. Certified Community Paramedic (CP-C) is also encourage.

   b. Vehicle operator is trained in defensive driving.

3. Medical Director

   a. The medical director is board-certified in family medicine, internal medicine, surgery, or pediatrics, or as appropriate to the program's scope of services. If fire department based, the medical director should be board-certified in emergency medicine and/or emergency medical services or have five years of experience in emergency medicine. The medical director should have demonstrated EMS and community paramedicine education and experience in telemedicine/telehealth.

4. Equipment

   a. Oral/pharyngeal airway

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b. Pulse oximeter

c. Sphygmomanometer

d. Thermometer

e. Automatic external defibrillator

f. Bag-valve mask

g. Glucometer

h. Adequate oxygen source

i. Hemorrhage Control Supplies/Equipment (such as tourniquets, packing materials)

j. Depends on state/local or national requirements, or medical director requirements (e.g., auto-injector)

5. Medications

   a. EMT may assist patient taking own medication

   b. Depends on state/local or national requirements, or medical director requirements

6. Interventions

   a. Basic emergency medical services

   b. Basic medical care as defined in the program's medical protocols

   c. Non-invasive vital sign measurement (e.g., blood pressure, pulse-oximetry)

   d. Minor wound care

   e. Exposure (Infection) control

   f. Depends on state/local or national requirements, medical director requirements

7. Quality – As defined in the program's Quality Management (QM) program.

CM 03.01.02 Advanced Care – An advanced care medical service is defined as the care of a patient whose condition warrants a medical practitioner commensurate with the scope of practice of a registered

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nurse (RN), practical nurse (PN),physician assistant (PA), paramedic, community paramedic or respiratory therapist (RT) who meets the criteria listed below. Patient is stable enough to remain out of the hospital and needs may include but not be limited to:

a. Use of oxygen

b. Emptying drainage bags

c. Dressing changes and wound care

d. Point of Care testing and collection of lab specimens

e. Medication administration and/or supervision

f. Dietary supervision

g. Potential for cardiac or diabetic complications such as angina or hypo/hyperglycemia

h. Potential for respiratory complications such as hypoxia, suctioning and humidity needs

i. Other physical, psychological or supportive care

Preface – appropriate Authority Having Jurisdiction (AHJ) applies – also includes all aspects of Primary Care

1. Scope of Care – Capability to deliver out of hospital advanced care

2. Clinical Practitioners

   a. A minimum of one medical practitioners who are licensed/certified according to state or national requirements. The vehicle operator is trained in defensive driving.

   b. The RN must have current and appropriate state licensure (in the state of residence or in a compact state or nation of residence) and a minimum of two years of experience as an RN in a hospital or pre-hospital setting. Education and certification as a Community Paramedic Technician and/or Community Paramedic Clinician is encouraged.

   c. The PA must have current and appropriate state licensure (in the state of residence or in a compact state or nation of residence) and a minimum of two years of experience as a PA in a hospital or pre-hospital setting. Education and certification as a Community Paramedic Technician and/or Community Paramedic Clinician is encouraged.

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d. The paramedic must be licensed, certified or permitted according to the appropriate state of residence regulations or by Authority Having Jurisdiction (AHJ) and have current relicensing, recertification or re-permitting status and a minimum of two years ALS experience. National registry (NREMP) and education and certification as a Community Paramedic Technician and/or Community Paramedic Clinician are encouraged. Certified Community Paramedic (CP-C) is also encouraged.

e.

f. The RT must have current and appropriate state licensure (in the state or nation of residence) and a minimum of 2 years' experience. Education and certification as a Community Paramedic Technician and/or Community Paramedic Clinician is encouraged.

3. Medical Director

a. The medical director is board-certified in family medicine, internal medicine, surgery, or pediatrics, or as appropriate to the program's scope of services. If fire department based, the medical director should be board-certified in emergency medicine and/or emergency medical services or have five years of experience in emergency medicine. The medical director should have demonstrated EMS and community paramedicine education and experience in telemedicine/telehealth.

4. Equipment – includes all equipment in Primary Care plus:

a. Cardiac monitoring (e.g., pacemaker/defibrillator)

b. Non-invasive monitoring (e.g., waveform capnography, pulse-oximetry)

c. Point of Care testing

d. Telemedicine/telehealth devices as supported by the program

5. Medications – include all medications in Primary Care plus:

a. Resuscitative medications by national EMS education and practice standards.

b. Medications based on the scope of services and patient population and approved by the medical director

6. Interventions – includes all interventions in Primary Care plus:

a. Advanced airway management (Endotracheal intubation, Supraglottic airway)

b. Phlebotomy

c. Point of Care testing

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d. Non-invasive CO2 monitoring

e. Peripheral IV

f. Waveform capnography for ventilated patients

7. Quality – As defined in the program's Quality Management (QM) program.

CM 03.02.03 Specialty Care - Capability to deliver out-of-hospital care at a specialty or subspecialty level (e.g., comparable, and limited, to that of a specialize clinical outpatient setting focused on a defined set of diagnosed system issues such as heart disease, pre and/or post-natal care, substance abuse, mental health, wound/trauma care or diabetes.)

Preface – appropriate Authority Having Jurisdiction (AHJ) applies – also includes all aspects of Primary Care

1. Scope of Care – Capability to deliver out of hospital care at a specialty or subspecialty level (e.g., comparable, and limited, to that of a specialize clinical outpatient setting focused on a defined set of diagnosed system issues such as heart disease, pre and/or post-natal care, substance abuse, mental health, wound/trauma care or diabetes.)

2. Clinical Practitioners

   a. As appropriate to the specialty

   b. Personnel must have current and appropriate state licensure (in the state of residence or in a compact state or nation of residence) and a minimum of two years of experience in a hospital or pre-hospital setting in the area of specialty. Education and certification as a Community Paramedic Technician and/or Community Paramedic Clinician is encouraged. Certified Community Paramedic (CP-C) is encouraged.

3. Medical Director

   a. The medical director is board-certified in family medicine, internal medicine, surgery, or pediatrics, or as appropriate to the program's scope of services. If fire department based, the medical director should be board-certified in emergency medicine and/or emergency medical services or have five years of experience in emergency medicine. The medical director should have demonstrated EMS and community paramedicine education and experience in telemedicine/telehealth.

4. Equipment – includes all equipment in Primary Care plus those appropriate to the specialty care.

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5. Medications – include all medications in Primary Care plus those appropriate to the specialty care.

6. Interventions – includes all interventions in Primary Care plus those appropriate to the specialty care:

    a. Advanced airway and pulmonary management (Endotracheal intubation, Supraglottic airway)

    b. Phlebotomy

    c. Point of Care testing

    d. Non-invasive CO2 monitoring

    e. Peripheral IV

    f. Waveform capnography for ventilated patients

8. Quality – As defined in the program's Quality Management (QM) program.

CM 03.02.00 MEDICAL DIRECTION

The medical director(s) of the program is a physician who is responsible for supervising and evaluating the quality of medical care provided by the medical practitioners. The medical director ensures, by working with the clinical supervisor and by being familiar with the scope of practice of the community paramedicine members and the regulations in which the care team practices, competency and currency of all medical practitioners working with the service.

CM 03.02.01 The medical director(s) should be licensed and authorized to practice in the location in which the medical service is based and have educational experience in those areas of medicine that are commensurate with the mission statement and scope of care of the community paramedicine service (i.e., adult, pediatric, new born, etc.) or utilize specialty physicians as consultants when appropriate.

CM 03.02.02 The medical director(s) should have experience in community paramedicine services and should have education as a medical director as appropriate to the mission statement and scope of care and be familiar with the general concepts of appropriate utilization of community paramedicine services. In addition, the medical director should be current and demonstrate competency or provide documentation of equivalent educational experiences directed by the mission statement and scope of care. Certifications are required as pertinent to the program's scope of care. For those services based in emergency medical services, the medical director(s) should be board-certified in Emergency Medicine and/or Emergency Medical Services. If a physician is board-certified in emergency certifications #1 and #11 are optional.

<u>Supporting Criteria</u>

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1. Advanced Cardiac Life Support (ACLS) according to the current standards of the American Heart Association or approved equivalent

2. Quality Management and appropriate utilization of community paramedicine services

3. Continuing education in community paramedicine and chronic disease management

4. Emergency Medical Services

5. Hazardous materials recognition

6. Human Factors – Crew Resource Management, Psychological First Aid (See References)

7. Infection control and use of personnel protective equipment

8. "Just Culture" or equivalent education is strongly encouraged

9. Patient care capabilities and limitations (i.e., assessment and invasive procedures)

10. Knowledge of the local community needs assessment

11. Pediatric Advanced Life Support (PALS) according to the current standards of the American Heart Association (AHA) or Advanced Pediatric Life Support (APLS) according to the current standards of the American College of Emergency Physicians (ACEP) or national equivalent (if pediatrics is part of the scope of care)

12. Stress recognition and management/resilience

13. Compassion fatigue

14. Sleep deprivation, sleep inertia, circadian rhythms and recognizing signs of fatigue

15. The medical director should demonstrate continuing education in community paramedicine to include telemedicine/telehealth as appropriate.

16. Safety and risk management (strongly encouraged)

CM 03.02.03 The medical director(s) is actively involved in the quality management (QM) program for the service.

CM 03.02.04 The medical director(s) is actively involved in administrative decisions affecting medical care for the service.

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CM 03.02.05 The medical director(s) establishes written criteria for patient enrollment into the community paramedicine program.

CM 03.02.06 The medical director sets and annually reviews medical guidelines (for current accepted medical practice), and medical guidelines are in a written format.

CM 03.02.07 The medical director(s) is actively involved in the hiring process, training, and continuing education of all medical practitioners for the service that includes involvement in skills labs, medical protocols or guideline changes or additions.

CM 03.02.08 The medical director receives safety and risk management training on an annual basis (strongly encouraged).

CM 03.02.09 The medical director assures those recommending or caring for patients in the program are provided with written periodic updates of the patient care provided by the community medical service and acts as a liaison with those physicians or agencies when needed.

Examples of Evidence to Meet Compliance:
There is evidence of the medical director's involvement with the program through meeting attendance records, education records, chart reviews etc.

CM 03.02.10 The medical director(s) ensures patient care plans are appropriate and safe for the patient's specific disease process/needs. The medical director ensures that care is coordinated between the community paramedicine practitioner and their physicians/health system.

CM 03.02.11 The medical director must maintain open communications with referring and accepting agents and be accessible for concerns expressed regarding controversial issues and patient management.

CM 03.02.12 The medical director will encourage research into best practices and contribute to published literature.

CM 03.02.13 Medical Control

1. If the medical director is unavailable, there are other physicians (who are trained and identified by the service) with the appropriate knowledge base to ensure proper medical care and medical control during care for all patient types served by the community paramedicine service.

Examples of Evidence to Exceed Compliance:
The medical director is involved in community paramedicine on a regional and/or national basis. The medical director participates in peer-reviewed published research regarding community paramedicine.

CM 03.03.00 CLINICAL CARE SUPERVISOR

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Responsibility for supervision of patient care provided by the various clinical care providers (i.e., RN, PA, RT, EMT, Paramedic, etc.) must be defined by the service. All patient care practitioners must be supervised by someone knowledgeable and legally enabled to perform clinical supervision. The clinical care supervisor and medical director(s) must work collaboratively to coordinate the patient care delivery given by the various professionals and to review the overall system for delivery of patient care.

CM 03.03.01 The clinical care supervisor should demonstrate currency in the following or equivalent educational experiences as appropriate to the mission statement and scope of care.

1. Advanced Cardiac Life Support (ACLS) according to the current standards of the American Heart Association or approved equivalent
2. Quality Management and appropriate utilization of community paramedicine services
3. Continuing education in community paramedicine and chronic disease management
4. Emergency Medical Services
5. Hazardous materials recognition
6. Human Factors – Crew Resource Management, Psychological First Aid (See References)
7. Infection control and use of personal protective equipment
8. "Just Culture" or equivalent education is strongly encouraged
9. Patient care capabilities and limitations (i.e., assessment and invasive procedures)
10. Knowledge of the local community needs assessment
11. Pediatric Advanced Life Support (PALS) according to the current standards of the American Heart Association (AHA) or Advanced Pediatric Life Support (APLS) according to the current standards of the American College of Emergency Physicians (ACEP) or national equivalent (if pediatrics is part of the scope of care)
12. Stress recognition and management/resilience
13. Compassion fatigue
14. Sleep deprivation, sleep inertia, circadian rhythms and recognizing signs of fatigue
15. The clinical care supervisor should demonstrate continuing education in community paramedicine to include telemedicine/telehealth as appropriate.
16. Safety and risk management (strongly encouraged)

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17. Writing and evaluating plans of care

CM 03.03.02 The clinical care supervisor is actively involved in the QM process.

CM 03.03.03 Knowledge of national and international regulations as appropriate to scope of practice.

Examples of Evidence to Exceed Compliance:
The clinical supervisor attends TEM and Just Culture training and achieves advanced certifications.

CM 03.04.00 PROGRAM MANAGER

The program manager may have overall responsibility for a program or for a specific base with or without additional clinical responsibilities. (Follow criteria above if clinical responsibilities are part of the position description.)

CM 03.04.01 The program manager must demonstrate currency in the following or equivalent educational experiences as appropriate to the mission statement and scope of care. Didactic education initially and on an annual basis should include but not be limited to:

1. Human Factors – Crew Resource Management, Psychological First Aid (See References)
2. "Just Culture" or equivalent education strongly encouraged
3. Knowledge of national and international regulations as appropriate to scope of care
4. Knowledge of the local community needs assessment
5. Quality Management of the program and its implication to best practices
6. Safety and risk management training on an annual basis (strongly encouraged)
7. Sleep deprivation, sleep inertia, circadian rhythms and recognizing signs of fatigue
8. Stress recognition, compassion fatigue and management/Resilience (See References)

CM 03.05.00 ORIENTATION AND CONTINUING EDUCATION

A planned and structured program should be required for all regularly scheduled primary, advanced and specialty care providers. Currency in these competencies must be ensured and documented through relevant continuing education programs/certification programs or their equivalent listed in this section. The orientation, training and continuing education must be directed and guided by the program's scope of care and patient population, mission statement and medical direction.

CM 03.05.01 Primary Care Community Medical Service

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1. Initial Training Program - Each Primary Care Community Medical Service provider must successfully complete a comprehensive training program or show proof of recent experience/training in the categories listed below prior to assuming independent responsibility.

a. Didactic Component - Should be specific and appropriate for the mission statement and scope of care of the community paramedicine service.

- Cell phone and established communications procedures including telemedicine/telehealth (if available)
- Compliance issues and regulations
- Hazardous materials
- Human Factors – Crew Resource Management, Psychological First Aid (See References)
- Developing Plans of Care
- Compassion Fatigue
- Infection control and use of personal protective equipment
- "Just Culture" or equivalent education is strongly encouraged
- Quality management
- Stress recognition and management/Resilience (See References)
- Sleep deprivation, sleep inertia, circadian rhythms and recognizing signs of fatigue
- Promotion of healthy lifestyle
- Medical equipment
- Metabolic/endocrine emergencies
- Oxygen use
- Post traumatic injury complications (adult and pediatric)
- Pediatric medical emergencies
- Pharmacology (basic, based on scope of care and license)
- Point of care testing (basic, such as glucose levels)

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- Respiratory emergencies
- Thermal, chemical, and electrical burns
- Toxicology

b. Clinical Component - Clinical experiences should include, but not be limited to, the following (experiences should be specific and appropriate for the position description, mission statement and scope of practice of the community paramedicine service):

- Primary Care
- Pre-hospital care
- Mental Health (Substance abuse, cognitive disorders, schizophrenia, psychotic disorders)
- At risk needs (physical and mental abuse, neglect, PTSD, malnutrition, medical illiteracy, fall risk)
- Special needs (autism, dementia, physical limitations, age)
- Wound Care
- Knowledge of wellness
- Knowledge of the local community needs assessment
- Cultural competencies (Religion, Language, Sexual Orientation, Ethnicity, Race)
- Prevention (Immunizations and screening, physical safety, personal risks)
- Health teaching
- Chronic disease management
- Scope and roles of other community resources

2. Continuing education/staff development - Continuing education must be provided and documented for Primary Care community medical service.

a. Didactic continuing education must include:

- Response vehicle - safety issues

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- Emergency care courses –basic level
- Hazardous materials recognition and response
- Human Factors – Crew Resource Management, Psychological First Aid (See References)
- Infection control and use of personal protective equipment
- Stress recognition, compassion fatigue and management/ Resilience (See References)
- Sleep deprivation, sleep inertia, circadian rhythms and recognizing signs of fatigue
- Knowledge of the local community needs assessment

b. Clinical continuing education should be developed and documented on an annual basis and must include:

- Emergency/ hospital care
- Pre-hospital experience
- Mental Health
- Wound Care

c. Clinical competency must be maintained by currency in the following or equivalent training as appropriate for the position description, mission statement and scope of care of the community paramedicine service.

- Basic Life Support (BLS) - documented evidence of current BLS certification according to the American Heart Association.
- Education specific to the community paramedicine environment
- Education specific to the types of patients outlined in the program's scope of services

3. Education Specific to the Community paramedicine Environment

    a. Completion of all the following educational components should be documented for each of the community paramedicine practitioners. These components should be included in initial education as well as reviewed on an annual basis with all community paramedicine practitioners.

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b. Patient care considerations (assessment/ treatment/ preparation/handling/ equipment)

c. On-site activities:

- Introduction to the patient, family and others present
- Care of the patient, including appropriate privacy and HIPAA considerations
- Home safety assessment
- Use of durable medical equipment (DME)
- Familiarization with all supplies and equipment if met by an ambulance (to be reviewed with ambulance personnel prior to transport)
- Development of exit strategies to discontinue services when no longer needed or appropriate.
- Telemedicine/telehealth as appropriate

CM 03.05.02 Advanced Care Community Medical Service

1. Initial Training Program – Each Advanced Primary Care Community Medical Service provider must successfully complete a comprehensive training program or show proof of recent experience/training in the categories listed below prior to assuming independent responsibility.

a. Didactic Component - Should be specific and appropriate for the mission statement and scope of care of the community paramedicine service.

- Airway and pulmonary management
- Anatomy, physiology, and assessment for adulty, pediatric and neonatal patients as applicable.
- Cardiac and cardiovascular systems management and emergencies
- Cell phone and established communications procedures, including telemedicine/telehealth (if available)
- Compliance issues and regulations
- Hazardous materials
- Human Factors – Crew Resource Management, Psychological First Aid (See

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References)

- Developing Plans of Care
- Compassion Fatigue
- Infection control and use of personal protective equipment
- “Just Culture” or equivalent education is strongly encouraged
- Quality management
- Stress recognition, compassion fatigue and management/ Resilience (See References)
- Sleep deprivation, sleep inertia, circadian rhythms and recognizing signs of fatigue
- Promotion of healthy lifestyle
- Medical equipment
- Metabolic/endocrine emergencies
- Oxygen use
- Post traumatic injury complications (adult and pediatric)
- Pediatric medical emergencies
- Pharmacology (based on scope of care, medical protocols and license)
- Point of care testing and collection of medical specimens
- Respiratory emergencies
- Thermal, chemical, and electrical burns
- Toxicology
- Disaster and triage
- Environmental issues and emergencies

b. Clinical Component - Clinical experiences should include, but not be limited to, the following (experiences should be specific and appropriate for the position description, mission statement and scope of practice of the community paramedicine service):

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- Emergency care
- Pre-hospital care
- Mental Health (Substance abuse, cognitive disorders, schizophrenia, psychotic disorders)
- At risk needs (physical and mental abuse, neglect, PTSD, malnutrition, medical illiteracy, fall risk)
- Special needs (autism, dementia, physical limitations, age)
- Wound Care
- Knowledge of wellness
- Knowledge of the local community needs assessment
- Cultural competencies (Religion, Language, Sexual Orientation, Ethnicity, Race)
- Prevention (Immunizations and screening, physical safety, personal risks)
- Health teaching
- Chronic disease management
- Palliative and hospice care
- Care coordination
- Scope and roles of other community resources

2. Continuing education/staff development - Continuing education must be provided and documented for Primary Care community medical service.

a. Didactic continuing education must include:

- Response vehicle - safety issues
- Emergency care courses – advanced level
- Hazardous materials recognition and response
- Human Factors – Crew Resource Management, Psychological First Aid (See References)
- Infection control and use of personal protective equipment

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- Stress recognition, compassion fatigue and management/ Resilience (See References)

- Sleep deprivation, sleep inertia, circadian rhythms and recognizing signs of fatigue

b. Clinical and laboratory continuing education should be developed and documented on an annual basis and must include:

- Skills maintenance program documented to comply with the number of skills required in a set period of time according to policy of the community paramedicine service.

- Appropriate clinical experiences pertinent to the community paramedicine program's scope of care.

c. Policies ensure that clinical competency is maintained by currency in the following or equivalent training as appropriate. See addendum B – the Education Matrix.

- Advanced Cardiac Life Support (ACLS) – documented evidence of current ACLS according to the AHA

- Basic Life Support (BLS) - documented evidence of current BLS certification according to the American Heart Association (AHA)

- Pediatric Advanced Life Support (PALS) according to the AHA - or Advanced Pediatric Life Support (APLS) according to ACEP, or equivalent education (if pediatrics is part of the scope of care)

- Neonatal Resuscitation Program (NRP) if scope of care includes care of infants 28 days old or less.

- Advanced nursing certifications are encouraged and must be current if required by position description

- EMT/paramedic certifications (EMT, paramedic, CCP-C) must be current if required by position description. Certification as a Community Paramedic – Certified (CP-C) within two years of the date of hire is strongly encouraged.

- RT certifications (RRT) must be current if required by position description

3. Education Specific to the Community Paramedicine Environment

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a. Completion of all the following educational components should be documented for each of the medical provider. These components should be included in initial education as well as reviewed on an annual basis with all medical practitioners.

b. Patient care considerations (assessment/ treatment/ preparation/handling/ equipment)

c.. On-site activities:

- Introduction to the patient, family and others present
- Care of the patient, including appropriate privacy and HIPAA considerations
- Home safety assessment
- Use of durable medical equipment (DME)
- Familiarization with all supplies and equipment if met by an ambulance (to be reviewed with ambulance personnel prior to transport)
- Development of exit strategies to discontinue services when no longer needed or appropriate.
- Telemedicine/telehealth as appropriate

CM 03.05.03 Specialty Care

1. Initial Training Program - Each Specialty Care Community Medical Service provider must successfully complete a comprehensive training program or show proof of recent experience/training in the categories listed below prior to assuming independent responsibility.

a. Didactic Component - Should be specific to the program specialty and appropriate for the mission statement and scope of care of the community paramedicine service.

- Cell phone and established communications procedures, including telemedicine/telehealth (if available)
- Compliance issues and regulations
- Hazardous materials recognition
- Human Factors – Crew Resource Management, Psychological First Aid (See References)
- Developing Plans of Care
- Compassion Fatigue

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- Infection control and use of personal protective equipment
- “Just Culture” or equivalent education is strongly encouraged
- Quality management
- Stress recognition, compassion fatigue and management/ Resilience (See References)
- Sleep deprivation, sleep inertia, circadian rhythms and recognizing signs of fatigue
- Medical equipment
- Metabolic/endocrine emergencies
- Oxygen use
- Post traumatic injury complications (adult and pediatric)
- Pediatric medical emergencies
- Pharmacology
- Respiratory emergencies
- Thermal, chemical, and electrical burns
- Toxicology

b. Clinical Component - Clinical experiences should be specific to the specialty and may include, but not be limited to, the following (experiences should be specific and appropriate for the position description, mission statement and scope of practice of the community paramedicine service):

- Primary Care
- Pre-hospital care
- Mental Health (Substance abuse, cognitive disorders, schizophrenia, psychotic disorders)
- At risk needs (physical and mental abuse, neglect, PTSD, malnutrition, medical illiteracy, fall risk)
- Special needs (autism, dementia, physical limitations, age)

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- Wound Care
- Knowledge of wellness
- Cultural competencies (Religion, Language, Sexual Orientation, Ethnicity, Race)
- Prevention (Immunizations and screening, physical safety, personal risks)
- Health teaching
- Chronic disease management
- Promotion of healthy lifestyles
- Palliative and hospice care
- Scope and roles of other community resources

2. Continuing education/staff development - Continuing education must be provided and documented for the specialty care community medical service.

a. Didactic continuing education must include:

- Response vehicle - safety issues
- Primary Care and preventing courses –basic level
- Hazardous materials recognition
- Human Factors – Crew Resource Management, Psychological First Aid (See References)
- Infection control and use of personal protective equipment
- Stress recognition, compassion fatigue and management**/** Resilience (See References)
- Sleep deprivation, sleep inertia, circadian rhythms and recognizing signs of fatigue

b. Clinical continuing education should be developed and documented on an annual basis and must include:

- Primary/ hospital care
- Mental Health

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- Wound Care
- Discharge planning and care coordination
- Education related to the program's specialty

c. Clinical competency must be maintained by currency in the following or equivalent training as appropriate for the position description, mission statement and scope of care of the community paramedicine service. (See addendum B – the Education Matrix.)

- Basic Life Support (BLS) - documented evidence of current BLS certification according to the AHA.
- Education specific to the community paramedicine specialty

.3. Education Specific to the Community Paramedicine Environment

a. Completion of all the following educational components should be documented for each of the community paramedicine practitioners. These components should be included in initial education as well as reviewed on an annual basis with all community paramedicine practitioners.

b. Patient care considerations (assessment/ treatment/ preparation/handling/ equipment)

c. On-site activities:

- Introduction to the patient, family and others present
- Care of the patient, including appropriate privacy and HIPAA considerations
- Home safety assessment
- Use of durable medical equipment (DME)
- Familiarization with all supplies and equipment if met by an ambulance (to be reviewed with ambulance personnel prior to transport)
- Development of exit strategies to discontinue services when no longer needed or appropriate
- Assessment of social determinants of care and referral for additional resources (food/shelter assistance, transportation, utilities (heat, phone, etc.), and substance use
- Telemedicine/telehealth as appropriate

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CM 03.06.00 ACCOMMODATIONS AT THE PATIENT CARE LOCATION

CM 03.06.01 Patient care locations should not compromise the ability to receive appropriate care if necessary.

1. Policies that address patient placement should allow for safe egress.
2. Policies that address barrier protection of medical equipment and supplies in non-health care locations.
3. Accessible to soap and water or disinfectant

CM 03.06.02 Policy will address methods and options for assuring patient privacy at the care locations.

CM 03.06.03 Delivering oxygen

1. Oxygen flow can be stopped at or near the oxygen source.
2. The following indicators are accessible to medical practitioners and the patient/family:
   a. Quantity of oxygen remaining
   b. Measurement of liter flow
3. A variety of oxygen delivery devices consistent with the patient's needs must be available.
   a. Equipment requiring batteries such as an oxygen concentrator must include additional batteries sufficient for the duration of care.
4. Knowledge of existing patient oxygen systems and contact information for requesting additional oxygen or serves.
5. Procedures or policies that outline where and how to handle prolonged power outages, or the need to evacuate the living situation for extended periods of time during a disaster.

CM 03.06.04 Maintaining IV Fluids

1. IV supplies and fluids are available if needed.
2. IV infusion pumps are available as appropriate.

CM 03.06.05 Accessible medications consistent with the service's scope of care.

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1. Controlled substances provided by the community medical service program are in a secured system or kept in a manner consistent with policy and with local, state, federal, and international regulations. It is recognized the patient may possess and self-administer their own medications and/or narcotics.

a. A policy to address securing/storage of controlled substances is required.

2. Storage of medications allows for protection from extreme temperature changes if environment deems it necessary.

3. There is a method to check expiration dates of medications on a regular basis.

4. There is a procedure or policy for disposing of medications consistent with local, state or federal law or regulations.

CM 03.06.06 Pressure Ulcers – Policies and procedures are written and followed to prevent pressure ulcers and/or reduce the impact of pressure ulcers.

1. Patient assessment and documentation of pressure ulcers is done during each patient visit according to program policy

2. Pressure reducing devices and/or methods are used when needed.

CM 03.06.07 Medical supplies and equipment must be consistent with the service's mission statement and scope of care.

1. A portable mechanical suction unit if need is anticipated

2. Glucometer is available

3. Pulse oximetry capabilities

4. Automatic blood pressure device or sphygmomanometer

6. Portable oxygen

7. Point of care testing

8. Telemedicine/telehealth unit if supported by the program

7. If a vehicle is used to make visits, the vehicle will be assessed in advance to the extent possible for the potential problems comprising the patient's stability addressed accordingly

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a. Supplemental lighting is available if needed, or a portable light with a battery source must be available.

b. Adapters and/or regulators must be accessible to and compatible with a power source.

c. Semi-automatic or automatic external defibrillator. Practitioners need to know how to use specific make and model of this equipment and how to check functionality of equipment and its batteries.

8. All equipment and supplies must be secured including containers for medical equipment along with locks, straps, or other mechanism for securing it.

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CM 03.06.08 Operational Issues

1. The community paramedicine service must ensure that all medical equipment is in working order and all equipment/supplies are validated through documented checklists.

a. Medical equipment must be periodically tested and inspected, per the manufacturer's requirements, by a certified clinical engineer.

b. Equipment inspections will be required according to the program's guidelines.

c. Adequate back-up battery supply must be available to ensure all medical equipment remains functional.

2. Occupant restraint devices - Medical practitioners must be in seatbelts at all times while vehicles are in motion.

3. Policy addressing the provision of contingency plans in the event of maintenance problems, adverse weather, changes in security issues, delays extending duty time beyond 12 hours, and other adverse occurrences. The policy will list resources available to personnel should these situations arise.

4. A policy sets criteria and guidelines for aborting a patient encounter prior to and during patient care.

5. A policy that addresses do not resuscitate (DNR)/allow natural death (AND)/physician's orders for life sustaining treatment (POLST)

6. A policy addresses transfer and security of patient's personal property if the patient must be moved.

CM 03.07.00 INFECTION CONTROL AND PREVENTION

Policies and procedures addressing patient care issues involving communicable diseases, infectious processes and health precautions for emergency personnel as well as for patients must be current with the local standard of practice or national standards (or in the U.S. - OSHA and as published by the Centers for Disease Control and Prevention).

CM 03.07.01 Policies and procedures must be written and readily available to all personnel of the community paramedicine service.

CM 03.07.02 There is an Exposure Control Plan consistent with national (in the U.S., OSHA) guidelines. The ECP includes:

1. A reference for work restrictions for personnel exposed to or infected with an infectious disease (reference Table 2.2 in Guide to Infection Prevention in EMS)

2. A list of the risks associated with diseases prevalent in coverage areas specific to the program.

3. A bloodborne pathogen program consistent with the OSHA Bloodborne Pathogen Standard (http://www.osha.gov/SLTC/blodbornepathogens/bloodborne_quickref.html)

CM 03.07.03 Education programs will include the program's infection control resources, programs, policies and CDC and OSHA recommendations (or equivalent national guidelines). In addition, initial and annual education regarding identification, management and safety related to patients with potentially infectious pathogens is documented.

CM 03.07.04 Education programs and policies regarding latex allergies may include:

1. Patients and employees at risk for latex sensitivities and symptoms manifested by an allergic reaction

2. Maintaining a latex-safe environment

3. Methods to minimize latex exposure to lessen risks of allergic reactions in clinical personnel

CM 03.07.04 Preventive measures - All personnel must practice preventive measures lessening the likelihood of transmission of pathogens. Policies and procedures address:

1. Personnel health concerns and records of:

    a. Pre-employment and annual physical exams or medical screening to include:

    - History of acute or chronic illnesses

    - Illnesses requiring use of medications that may cause drowsiness, affect judgment or coordination

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• Provide annual tuberculosis testing (purified protein derivative) especially if services are provided in high risk areas and other testing, screenings, and vaccinations as consistent with current national (CDC in the U.S.) guidelines. The CDC may deem the localized region low risk and annual testing not necessary, but this applies only if the service does not operate or respond outside of the local region.

• Immunization history appropriate to the scope of practice. Practitioners are encouraged to have tetanus immunization (Measles, mumps, and rubella (MMR) immunizations are encouraged for those born after 1957.) "Hepatitis B vaccine must be offered and if the employee has not previously had the vaccination or does not have adequate titers and declines, the program must have a signed declination form per OSHA or equivalent standard. The flu vaccine is required unless contraindicated by policy.

• Immunization history is documented and monitored for currency and appropriateness

2. Management of communicable diseases and infection control in the community paramedicine environment is outlined in policies.

a. Personal protective equipment is readily accessible in the service vehicle or issued to the medical team. Available protective equipment must include gloves, gowns, masks and eye/face protection.
   i. Annual fit testing must be completed, as appropriate.
   ii. Reusable equipment must be inspected and maintained following the manufacturer's instructions.

b. Use of safety needles and blunt or other type system to lessen the risk of needlesticks to those who may come into contact with them

c. Sharps disposal container for contaminated needles and collection container for soiled disposable items on the vehicle and at the care sites, and proper disposal of same

d. Cleaning and disinfecting with appropriate disinfectant of the equipment and personnel's soiled clothes

e. Proper cleaning or sterilization of all appropriate instruments or equipment following each patient contact

f. Hand hygiene is performed before and after touching a patient, before clean/aseptic procedures, after body fluids exposure risk, after touching patient's surroundings, before handling medications, after leaving the care site and before and after removing gloves

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• Hand washing with an antimicrobial soap and water is indicated when hands are visibly soiled, contaminated with proteinaceous material or exposed to body fluids. However, it is recognized that this may not be possible in the community paramedicine environment in which case an alcohol-based hand rub should be used. An alcohol-based hand rub is preferred for all other hand hygiene.

g. Management maintains documentation related to bloodborne and airborne pathogens including confidential records of exposure incidents and post-exposure follow-up, hepatitis B vaccination status and initial and on-going training for all employees.

• Post exposure follow-up includes: identification and testing of source patient, baseline, and follow-up testing of exposed employee, making counseling resources available, and offering Hepatitis B vaccination.

h. A policy addresses access to post exposure prophylaxis (PEP) medications for HIV, meningococcal infections, etc. The PEP medications should be available in a timely manner for all team members.

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CM 04.00.00 COMMUNICATIONS AND SERVICE PLANNING

Medical providers plan and follow a specific visit as follows:

CM 04.01.01 If telecommunication devices (phone, video, text, etc.) are part of the communications equipment, they are to be used in accordance with safety and HIPAA policies.

CM 04.01.02 A coordinator must be assigned to receive and coordinate all requests for the community paramedicine service.

CM 04.02.00 TRAINING OF THE DESIGNATED COORDINATOR

CM 04.02.01 Should be commensurate with the scope of responsibility of the service.

1. Medical terminology

2. Knowledge of prevention, primary and emergency care – roles and responsibilities of the various levels of training - BLS/ALS, EMT/ Paramedic, etc.

3. Knowledge of the use of multidisciplinary teams

4. Knowledge of appropriate contacts and procedures – foreign language resources, hospital and agency resources, abort/cancellation procedure, common logistical problems, and troubleshooting/response plans, etc.

5. Relevant regulations as appropriate to scope of service

6. General safety rules and emergency procedures pertinent to community paramedicine and the service provider following procedures

7. How to retrieve current and forecasted weather to assist medical providers

8. Sleep deprivation, sleep inertia, circadian rhythms and recognizing signs of fatigue

9 Stress recognition, compassion fatigue and management to include resources for Critical Incident Stress Debriefing or other type of post-critical incident counseling

10. Customer service/public relations/phone etiquette and de-escalation procedures

11. Quality management

12. Crew Resource Management (CRM) pertinent to communications

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13. Computer literacy and software training

15. Post-Accident/Incident Plan (PAIP) or Emergency Action Plan (EAP)

CM 04.02.03 There is evidence of recurrent training and of training as policies and equipment changes occur. This also includes:

1. Crew Resource Management (CRM) pertinent to communications
2. Post-Accident/Incident Plan (PAIP)
3. Sleep deprivation, sleep inertia, circadian rhythms and recognizing signs of fatigue
4. Stress recognition, compassion fatigue and management to include resources for Critical Incident Stress Debriefing or other type of post-critical incident counseling
5. Availability and access to employee assistance program(s)

CM 04.03.00 POLICIES

CM 04.03.01 A readily accessible post-incident/accident plan so that appropriate search efforts may be initiated in the event communications cannot be established with medical practitioners or location determined within a pre-planned time frame.

1. Written post-incident /accident plans are easily identified, readily available and understood by all personnel and minimally include:

    a. List of personnel (with current phone numbers) to notify in order of priority (for coordinator to activate) in the event of an incident/accident. This list should include:

    - Program leadership
    - Risk management/attorney
    - Family members of team members
    - Family of patient
    - Referring hospital and receiving hospital
    - Human resources (as applicable)

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- Media relations or pre-identified individual who will be responsible for communicating with the media, state health department and other team members.

b. A method to insure accurate information dissemination

c. Notification plans include appropriate family members and support services to family members following a tragic event. There must be timely notification of next of kin. Next of kin is no longer strictly defined at the federal level, so the crew member determines this on a data sheet and reviews annually. It is strongly recommended that:

- Family assistance includes coordination of family needs immediately after the event e.g. transportation, lodging, memorial/burial service, condolences, initial grief support services/referrals, (usually through appointment of a family liaison).

- Continuity includes follow through with the family after the event (e.g., the continuation of grief counseling and support referrals, the inclusion of families in decision-making on anniversaries/memorials, and check-ins following release of NTSB reports, or equivalent, etc.)

d. Consecutive guidelines to follow in attempts to:

- Communicate with the medical practitioners

- Initiate support as appropriate (law enforcement, mental health, lift assist, etc.)

- Have a back-up plan for care of the patient

e. Preplanned time frame to activate the post-accident/incident for overdue communication point

f. Procedure to document all notifications, calls, communications and to secure all documents related to the particular incident/accident

g. Procedure to deal with releasing information to the press

h. Resources available for CISD (critical incident stress debriefing) or other counseling alternatives

i. Process to determine whether the program will remain in service

2. An annual drill is conducted to exercise the post-accident/incident plan.

3. A test of all emergency procedures that may include fire drill, intruder on premises, catastrophic failure of the communications center, forces of nature etc. will each be conducted on

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an annual basis (as applicable to community paramedicine services with a dedicated communications center or base)

CM 04.04.00 COORDINATION AND TRACKING

CM 04.04.01 Initial coordination must be documented, and a service coordinator should be contacted at each departure and arrival, or other designated checkpoints.

1. These items to include but not be limited to:

    a. Name, agency (or person requesting the referral) and telephone number of caller

    b. Patient type/condition

    c. Date and time call received

    d. Anticipated or scheduled date/time of service

    e. Location of patient

    f. Name of each patient care provider assigned to the service

    g. Copy of available medical records from a referring healthcare facility or physician

    h. Additional information as appropriate to the request such as:

    - Special diet requirements
    - Ground transportation and ambulance name and contact information for additional services or referrals

2. Specific methods must be used by the coordinator for contacting the medical practitioners to relay request information, i.e., pager numbers, telephone and/or cellular numbers.

3. An on-call roster of the medical team must be provided to the coordinator that includes a priority phone list of personnel to notify in the event of an emergency.

4. Management requires a post service debrief be conducted with the service coordinator and/or the clinical supervisor after each patient visit.

CM 04.04.02 Patient Encounter Tracking – Communications during a patient encounter should also be documented accordingly:

1. Direct or relayed communications to coordinator specifying all departure and/or arrival times.

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CM 04.04.03 The Coordination Point must contain the following:

1. At least one dedicated phone line for the community paramedicine service

2. Capability to notify on-call personnel and on-line medical direction (through radio, pager, telephone, etc.)

3. A status board or electronic display with information about pre-scheduled medical visits, personnel on-call, etc.

4. Communications policy and procedures manual

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CM 05.00.00 COMMUNITY PARAMEDICINE VECHICLE OPERATIONS

For those program's using program owned vehicle(s) the following standards apply:

CM 05.01.01 The vehicle will be licensed in accordance with the applicable authority having jurisdiction (AHJ) laws and regulations.

CM 05.01.02 There is a written policy that addresses speed limitations and all aspects of traffic law compliance that pertain to vehicle operations.

CM 05.01.03 There is a written policy that describes the appropriate use of operating with lights and sirens (if so equipped). The policy includes who can initiate use and under what circumstances, such as only when time is critical to the patient's outcome. The vehicle must come to a complete stop at intersections as appropriate (where the traffic light is red or there is a stop sign) including when operating with lights and sirens. Transports using red lights and sirens are tracked and trended in the QM process (see Quality sections of 02.01.07).

MC 05.01.04 There is a written policy that addresses a procedure to follow when the vehicle comes upon an accident scene. Policy must be consistent with state regulations.

CM 05.01.05 There is a written policy that outlines a procedure to follow when the vehicle is involved in an accident with damage and/or injuries.

CM 05.01.06 There is a written policy outlining the procedure for a mandatory drug test of the vehicle operator after an accident with an injury or serious damage.

CM 05.01.07 There is a written policy outlining the procedure to follow when the vehicle breaks down.

CM 05.01.08 There is a written policy dealing with safety aspects of operating a vehicle:

1. Vehicle operator duty and rest time

2. Inclement weather and responsibility for aborting the patient encounter if there is a safety concern

3. Driving and operator records (speeding and other traffic violations) are reviewed by management minimally upon hire and then annually

CM 05.02.00 VEHICLE AND EQUIPMENT

CM 05.02.01 The vehicle is equipped with road hazard equipment to be used in the event of a breakdown.

1. Road hazard equipment must minimally include:

    a. Flashlight

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b. Road marking device – cones, flares or triangles, for example

c. Tools for small repairs - wrench, screwdrivers, for example

d. Leather, heavy-duty gloves

e. Reflective vests (one for each potential occupant)

f. Equipment for dealing with snow as appropriate to the environment

CM 05.02.02 A secondary means of communication, other than a cell phone, is encouraged between:

1. The vehicle operator and medical control
2. The vehicle operator and public safety agencies

CM 05.02.03 Radio frequencies are consistent with the state EMS radio communications plans.

CM 05.02.04 If oxygen or other compressed gases are carried, an appropriate securing device must be installed to keep the tank(s) secure during vehicle movement.

CM 05.02.05 If carried, controlled substances are in a locked system and kept in a manner consistent with local and national regulation.

CM 05.02.06 Storage of medications allows for protection for extreme temperature changes.

CM 05.02.07 Securing Equipment

- All medical equipment, supplies and ancillary equipment (charges, battery packs, etc.) must be secured to prevent them from becoming a projectile in the event of turbulence or a crash.
- Velcro is not to be used to secure equipment or devices.
- If straps or belts are used to secure equipment, they must be rated to keep the weight and configuration in place to a minimum of a G-force of five.
- Rated cargo nets are strongly preferred over individual straps or belts to secure equipment bags.

CM 05.03.00 WEATHER

CM 05.03.01 There must be a written policy addressing weather/environmental conditions that prohibit vehicle use, such as zero/zero visibility and highway patrol road closures.

CM 05.04.00 VEHICLE OPERATOR

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CM 05.04.01 Vehicle operator must have a minimum of 2 years' experience as a licensed driver,

CM 05.04.02 Vehicle operators are required to complete defensive driving training program that is developed by the provider or outside agency.

CM 05.04.03 Operators of boats or other surface vehicles must demonstrate completion of initial training.

CM 05.04.04 The defensive driving training program must be repeated for each vehicle operator at least every 2 years or more frequently if involved in an "at fault" accident.

CM 05.04.05 Vehicle "co-pilot" responsibilities and duties (if more than one person is on board):

1. Vehicle co-pilot will have assigned duties to support the vehicle operator

    a. In navigation – setting/verifying GPS input

    b. Monitoring vehicle operator fatigue/impairment – the vehicle co-pilot is expected to stay alert at all times while the vehicle is in motion

    c. Cell phone and computer use not essential are prohibited during vehicle operation.

CM 05.05.00 VEHICLE MAINTENANCE

CM 05.05.01 Each vehicle must be maintained in full operating condition and in good repair, and documentation of maintenance must be kept on file. In addition, there must be a regular documented preventive maintenance program in accordance with the requirements of the manufacturer and other regulatory agencies.

1. There are documented daily checks of the vehicle for damages and equipment failure.

2. Major vehicle fluid and tire pressure checks are completed twice a week at a minimum.

CM 05.05.02 There must be no evidence of damage penetrating the body of the vehicle or holes that may allow exhaust gases to enter the vehicle.

CM 05.05.03 The interior of the vehicle, including all storage areas, must be kept clean in compliance with OSHA (or equivalent) standards, that is free of dirt, grease and other biohazardous or noxious matter.

CM 05.05.04 The vehicle must be cleaned as appropriate. All interior surfaces in the vehicle and medical equipment surfaces that came in contact with the patient or patient body fluid (including respiratory aerosolization) must be immediately cleaned and disinfected or disposed of in a secure biohazard container.

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CM 05.05.05 The mechanic must have experience as a certified mechanic in a shop environment, or the maintenance must be done at a certified shop specific for the make and model of the vehicle.

CM 05.05.06 The mechanic must be trained in infection control and educated to the dangers of unauthorized use of medical equipment, or a policy and practice must exist requiring the removal of medical waste, regulated equipment and regulated supplies, including non-over-the-counter medications, prior to vehicle servicing.

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