COMMUNITY PARAMEDICINE

Request for Service Form Completion Guidelines

Community Paramedics act as an extension of primary care. Community Paramedics increase system capacity by addressing inequities and access to healthcare.

Considerations when submitting a request for service form:

- Community Paramedics are not replacing or duplicating current services offered. For example, there are phlebotomy and transportation services that exist. Community Paramedic involvement is not to replace these existing services.
- Patients who are eligible for long-term care, soon to be eligible for long-term care, or on the long-term care waitlist are ideal patients for the program.
- Before making a referral for a blood draw, it is important to ask yourself if any of the following applies to the patient:
    - Severe mobility issues
    - Financial vulnerability
    - Inability to access transportation services
    - Palliative patient
    - Current Community Paramedicine patient
- When requesting any CP services in the homes, identify the barriers for the patient leaving their home
- We still provide response to emergency calls in the community, therefor exact times for scheduling appointment can be difficult and can change
- Requests for Service will remain open for up to 6 months. If services are required beyond 6 months, a consult will take place with the patient's care team to determine why and identify next steps.
- The following requests for service are considered one time only, and will be closed upon completion if the patient is not an active patient of the community paramedicine program, and no further action is required:
    - COVID 19 swab to be admitted to hospice
    - COVID 19 swab for long-term care admission

Sections 1 through 4: Patient and Referral Source Information, Patient Consent, and Risk Factors

- Please ensure these sections are completed in their entirety.
- If a patient has a DNR, we need a copy of it, or need to know location in the home.
- You must obtain patient consent before making a referral to the CP Program.
- If this is a subsequent referral for an existing patient and no information has changed, sections 1 and 4 (patient information, and risk factors) do not need to be completed, but referral source information and patient consent are required.

Section 5: Brief Medical History and List of Medications

- Please ensure you are including most up to date medical history of patient and list out any allergies and medications. If easier to attach medications, please check box and send the list with the request for service form.

Section 6: Reason for Referral

- Please indicate here what you are trying to achieve for the patient. This includes the goals of care for the patient, provider, and CP involvement. Please be as specific as possible.
- Indicate here what goal(s) you are trying to achieve through CP home visits.

Sections 7 through 10: Supports in Place, Services Requested, Safety Precautions, and Attachments

- Any support services in place should be identified. We do not want to duplicate services.
- It is important to identify safety precautions to health and safety of all.
- Attachments section is there to remind the referrer to attach a lab requisition if applicable, and the POA if applicable.
- Request for Service form must be signed by the requesting professional (physician, nurse practitioner, registered nurse). Patient reports/updates from CP Services delivered will be returned to the designated requesting professional.
- Assessments completed during subsequent visits are based on the patient's diagnosis and are guided by clinical practice guidelines specifically created to support Community Paramedic Program and care reviewed and signed off by the patient's primary care or most responsible physician. Additional assessments or education are to be selected as needed.
- The *National Early Warning Score, version 2* (NEWS2) was developed in England for the purposes of identifying high risk and or acutely ill patients using a standard group of six physiologic measurements: respiratory rate, oxygen saturation, systolic

blood pressure, pulse rate, level of consciousness and temperature. A score of 0-3 is assigned in each physiologic category with the aggregate score identifying level of both risk and response. While originally intended to identify patients at high risk for sepsis, its scope has expanded to include other high-risk patients. Patients to Consider: Any patient with a single abnormal vital sign or if the Paramedic has concerns for patient deterioration. The electronic health record may automatically calculate this when all data is entered.

- I-STAT is new for point of care, and below is a brief outline of what it is used for:
  - Used according to physician order and service capacity/cartridge availability
  - Available tests/cartridges include Chem8+, CG4+ and PT/INR
  - **Chem8+ includes:** Sodium (Na), Potassium (K), Chloride (Cl), Ionized Calcium (iCa), TCO2, Glucose (Glu), Urea Nitrogen (BUN)/Urea, Creatinine (Crea), Hematocrit (Hct), Hemoglobin* (Hgb)
  - **CG4+ includes:** Lactate, pH, PCO2, PO2, TCO2*, HCO3* (Base Excess (BE)*, sO2), *Calculated values
- Remote Patient Monitoring provides Community Paramedics and identified Healthcare Providers with biometric data and alerts when there are changes in their patient's health condition. The below chart includes the reading thresholds which can be tailored by the patient's physician or nurse practitioner.

Remote Patient Monitoring Threshold		
Congestive Heart Failure (CHF)	Weight	1 kg increase in 24 hours
		2 kg increase in 48 hours
		≥3 kg increase in 7 days
	SpO_2	<92%
	SBP	>180 mmHg
		<90 mmHg
	DBP	>110 mmHg
Diabetes Management	Blood Glucose	24-30 mmol/L (medium)
		3-4 mmol/L (medium)
		>30 mmol/L (high)
		<3 mmol/L (high)
		>18 mmol/L over 3 consecutive readings
COPD	SpO_2	<88%
		>95% if on O_2 therapy
	HR	>110 bpm
		<50 bpm