

New Hampshire

COVID-19 Temporary
Mobile Integrated Healthcare
Prerequisite Protocol

Administrative Packet

April 15, 2020

COVID-19 Protocol

Temporary Mobile Integrated Healthcare

Introduction

The New Hampshire Department of Safety, Division of Fire Standards and Training & Emergency Medical Services (FSTEMS) recognizes that during the COVID-19 state of emergency, patients with non-emergent diagnoses and symptoms, whether COVID-19 related or not, may be better treated in settings outside of the hospital, such as their homes, while hospitals are experiencing a significant increase in patients with COVID-19. In support of these efforts, FSTEMS will accept applications for Mobile Integrated Health (MIH) programs seeking temporary approval for MIH programs during the COVID-19 emergency. The temporary approval for an MIH programs will expire ninety (90) days after the termination of the state of emergency or public health/safety incident, as declared by Governor Sununu on March 13, 2020. FSTEMS will contact approved programs within 30 days after the end of the state of emergency to discuss an appropriate step-down plan for each program, including but not limited to how to apply for a permanent MIH approval or an appropriate plan to cease operations.

EMS Providers have traditionally functioned as a mobile healthcare unit and are a logical means of providing healthcare to the community as an extension of the primary care network, provided that a formal process has been followed, as outlined in this protocol. Only those EMS Units that have applied for, and have been approved by the NH BEMS under this prerequisite protocol, and only EMS providers who have met the requirements of this protocol may practice under these guidelines.

Definition of Mobile Integrated Healthcare

Mobile Integrated Healthcare (MIH) is the provision of healthcare using patient centered, mobile resources in the out-of-hospital environment.

In NH the MIH concept is envisioned to be an organized system of services, based on local need, which are provided by EMT's, AEMT's and Paramedics integrated into the local health care system, working with and in support of physicians, mid-level practitioners, home care agencies and other community health team colleagues, and overseen by emergency and primary care physicians. The purpose of the initiative is to address the unmet needs of individuals who are experiencing acute healthcare issues. It is not intended to address long-term medical or nursing case management.

General Project Description

The COVID-19 pandemic will result in many residents and visitors of New Hampshire needing to quarantine secondary to signs and/or symptoms of the virus or other healthcare conditions. These residents and visitors will need to be evaluated and followed as they remain in place. Many of these residents and visitors will fall outside the homecare agencies purview and EMS is in a unique position to assist in the evaluation and following of these citizens.

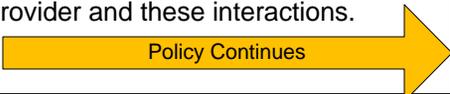
Provide a list of the hospital, homecare, and any other community partners involved in the MIH program, and the methodology for addressing the need (including any enhancements of the EMS response system that will result). If there is no local home health agency in the area, or if the local home health agency is unable or unwilling to collaborate with the EMS unit, the applicant shall document this in the application, including a description of the efforts undertaken to engage the local home health agency in collaboration.

Community Needs Analysis

COVID-19 State of Emergency

Patient Interaction Plan

Describe the nature of anticipated patient care and diagnostic interactions. Specify how the patient community will be educated to have realistic expectations of the MIH provider and these interactions.

Policy Continues 



Protocol Continues

Staffing Plan

Define who will be providing the MIH services and how these services fit within the normal EMS staffing of the Unit. Specify the schedule during which these services be made available and how the associated staffing arrangement will be funded.

Training Plan

Describe what training will be provided to enable the providers to deliver the services described above. List the objectives and outcomes of the training plan. Document who is responsible for training oversight and coordination and their qualifications.

There must be a credentialing process in place, with documentation of each EMS Provider's participation in it. Such a process shall be approved by the EMS Unit's Medical Director(s).

Quality Management Program and Data Collection

The EMS Unit shall conduct a quality management (QM) program specifically for the community healthcare program. The QM program will incorporate all the components of an EMS QM program as specified in [Administrative Rule Saf-C 5921](#).

Describe what data demonstrates the need for this project, if any. Describe the data to be collected to demonstrate the impact of this project on the population served. Describe the data reporting plan and how the NH Bureau of EMS will be included in it.

Documentation

The EMS Provider may at any time, using their own discretion, decide to activate the 911 system for emergency treatment and transport to appropriate care.

Electronic patient care reports of all community healthcare patient encounters must be submitted according to policies developed in coordination between the EMS Unit, MRH, collaborating home health agency and medical practice. Copies of these records shall be maintained by the EMS Unit, and be available for review by the NHBEMS.

The EMS Unit will participate in electronic data entry as required by the NHBEMS.

Medical Direction

Must establish a collaborative working relationship between the EMS Physician Medical Director or designee, who will be responsible for operations and continuous quality improvement, and a primary care provider providing medical direction for MIH services.

The New Hampshire Department of Safety, Division of Fire Standards and Training & Emergency Medical Services (FSTEMS) recognizes that during the COVID-19 state of emergency, patients with non-emergent diagnoses and symptoms, whether COVID-19 related or not, may be better treated in settings outside of the hospital, such as their homes, while hospitals are experiencing a significant increase in patients with COVID-19. In support of these efforts, FSTEMS will accept applications for Mobile Integrated Health (MIH) programs seeking temporary approval during the COVID-19 state of emergency. The temporary approval for an MIH program will expire ninety (90) days after the termination of the state of emergency or public health/safety incident, as declared by Governor Sununu on March 13, 2020. FSTEMS will contact approved programs within 30 days after the end of the state of emergency to discuss an appropriate step-down plan for each program, including but not limited to how to apply for a permanent MIH approval or an appropriate plan to cease operations.

Application Requirements:

1. Letter of Intent: This is a letter, on the letterhead of the New Hampshire licensed EMS service(s) applying for approval of a temporary MIH program, formally submitting the application to the Bureau of EMS for consideration. It should state the service's intent to support and staff the project during the state of emergency. The letter should be signed by the Administrator or Chief of the service whose name is on file at New Hampshire EMS.
2. Scope of Project: This is a project that addresses specific community health needs that are not being adequately met by other health provider resources. Ideally, it also will enhance EMS response resources in the community. All licensed EMS providers may participate in the project within their scope of practice. Training, medical direction, quality management, and data collection will be specific to the community health need being addressed, as will relationships with others in the community's health team.
3. General Project Description and Needs Assessment: Describe the service base location(s) to be employed, a list of the hospital, homecare, and any other community partners involved in the MIH, and the methodology for addressing the need (including any enhancements of the EMS response system that will result). If there is no local home health agency in the area, or if the local home health agency is unable or unwilling to collaborate with the EMS unit, the applicant shall document this in the application, including a description of the efforts undertaken to engage the local home health agency in collaboration. We will accept COVID-19 state of emergency as the "need".
4. Patient Interaction Plan: Describe the nature of anticipated patient care and diagnostic interactions. Specify how the patient community will be educated to have realistic expectations of the mobile integrated healthcare practitioners and these interactions. Additionally, educating the patient that this is a temporary service that may end after the state of emergency has been lifted.
5. Staffing Plan: Who will be providing the MIH services; on what type of schedule will these services be made available? How many qualified and licensed EMS providers will be employed?
6. Training Plan: What training will be provided to enable the providers to deliver the services described above? Who will be responsible for training oversight and coordination and what are the qualifications of this person to do so?
7. Medical Direction/Quality Management Plan: Identify the service's EMS medical director and describe his/her involvement in the service's operation and its quality management program. Identify the primary care physician who will provide medical direction for the MIH services to be delivered and describe the protocols developed for MIH patient interactions.
8. Data Collection and Plan: Submit data through TEMSIS MIH data points.

Temporary MIH Checklist:

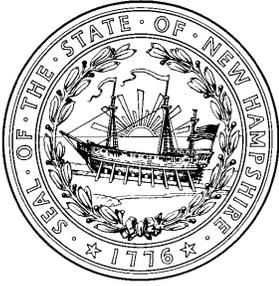
- A completed application, signed by both the EMS head of unit and medical director.
- Letter of Intent
- Scope of the program, including general description and identified needs
- Proof of collaboration with hospital, homecare and other community partners
- Patient interaction plan
- Staffing plan
- Training plan
- A letter from your medical director attesting to your competencies.
- A quality management plan to include your medical director
- Data collection

Submit your application to:

Vicki Blanchard, Captain
Clinical System
NH Fire Academy and EMS
33 Hazen Drive
Concord, NH 03303

Or scan and email to vicki.blanchard@dos.nh.gov

For questions, contact Captain Blanchard at the email above or 603-223-2400.



**NEW HAMPSHIRE
DEPARTMENT OF SAFETY
DIVISION OF FIRE STANDARDS AND TRAINING &
EMERGENCY MEDICAL SERVICES
NH EMS PREREQUISITE APPLICATION**
PLEASE PRINT (BLACK INK) OR TYPE



PROTOCOL NAME _____ PROTOCOL NUMBER _____

LEGAL NAME OF UNIT _____ UNIT LICENSE NUMBER _____

BUSINESS STREET ADDRESS _____
STREET CITY STATE ZIP CODE

MAILING ADDRESS _____
STREET/PO BOX CITY STATE ZIP CODE

HEAD OF UNIT _____ TITLE _____

CONTACT TELEPHONE _____ FAX (IF AVAILABLE) _____

EMAIL ADDRESS (IF AVAILABLE) _____

MEDICAL RESOURCE HOSPITAL _____

MEDICAL DIRECTOR OR DESIGNEE _____

MEDICAL DIRECTOR PHONE _____

TYPE OF APPLICATION (CIRCLE) INITIAL RENEWAL

 HEAD OF UNIT DATE MEDICAL DIRECTOR OR DESIGNEE DATE

ATTACHED IS SUPPORTING DOCUMENTATION FOR ALL ELEMENTS LISTED IN Saf-C 5922.01 (e) WITH A LIST OF LICENSING PROVIDERS TRAINED UNDER Saf-C 5922.

PART Saf-C PATIENT CARE PROTOCOLS

Saf-C 5920.01 Procedures...

(d) Prerequisites required by protocol shall be established by the EMS Medical Control Board in accordance with RSA 153:A-2 XVI (a).

(e) Protocol prerequisites, when required, shall address each of the following elements:

- (1) The protocol title and number to which the prerequisites relate;
- (2) The provider licensure level necessary to carry out the protocol;
- (3) The name of the medical director, or designee, who will oversee the training module;
- (4) The MRH and EMS head of unit recommendations to the division;
- (5) The provider experience criteria;
- (6) All quality management program elements;
- (7) Reporting requirements for monitoring and skill retention;
- (8) Equipment and staff support resources necessary;
- (9) Provider renewal criteria, and
- (10) Training requirements.

The following is an example of a Temporary MIH Packet
Letter of Intent: On EMS Agency Letterhead

Date

Vicki Blanchard, Captain
Clinical Systems
NH Fire Academy & EMS
33 Hazen Drive
Concord, NH 03303

RE: Temporary Mobile Integrated Healthcare (MIH) Letter of Intent

Dear Captain:

We respectfully submit our application packet for our temporary MIH program, protocol 7.3 Mobile Integrated healthcare. We are requesting an initial approval for ninety (90) days after the termination of the state of emergency or public health/safety incident, as extended by Governor Sununu on April 4, 2020.

Primary Care medical direction will be provided by primary physician's name. The EMS Medical Director will be medical director's name. The program designee will be Title, Name. The designee will work the Medical Director to oversee operations, education and quality management.

Staffing will be at the enter level of provider level with providers participating in locally developed education. Candidates will be selected based on experience, education and affective characteristics that best serve the change in role.

Quality management elements will be met through a variety of means. Weekly or monthly meetings with EMS leadership and the staffing. Weekly or monthly meetings with EMS leadership and our Medical Director. Additionally we will meet with our stakeholders and partners to review quality performance.

All necessary equipment, staff support and other resources will be provided by insert who will be providing.

This plan has been developed in collaboration with our homecare providers, XYZ Homecare. While the primary entry into the program will be through EMS recommendation to stay in place, it will be important to communicate information with our homecare partner.

This letter of intent also serves as recommendation of support for the project from the Medical Director, the Medical Resource Hospital and EMS Head of Unit.

Name
Head of EMS Unit

Name
Medical Director

Scope of Project

The CORVID-19 pandemic will cause many residents and visitors of New Hampshire to quarantine when showing signs and/or symptoms of the virus or other healthcare conditions. These citizens will need to be evaluated and followed as they stay in. Many of these citizens will fall outside the homecare agencies purview and EMS is in a unique position to assist in the evaluation and following of these citizens.

Patient Interaction

Example: As we responds to emergency calls and following our COVID-19 Protocol advises a patient to remain home, we will also seek permission to return to re-assess them on a cycle which will fit the volume being experienced at the time. This could be daily, every other day, or weekly. During the re-assessment the MIH provider will also reconcile any medication the patient has. We know that medication reconciliation is a benefit of other MIH programs. With a provider in the home, the patient's actual medications can be evaluated. Outdated and old dosage medications can be properly disposed of in order to prevent medication errors. If a patient had difficulty obtaining a new medication, the MIH provider can immediately identify this potentially life threatening issue and seek solutions to obtain the medications. In addition to the physical patient assessment and medication reconciliation, the MIH provider will also focus on the home and social services. Does the patient have family/community support? Are they in need of food or other needs? EMS will obtain patient's PCP contact and advise them of their interaction with the patient. If the patient does not have a PCP, EMS will advise their Medical Director.

Example: In collaboration with primary care physician office/urgency care name, EMS agency name will perform home visits to assess and report findings to PCP/urgent care. . During the re-assessment the MIH provider will also reconcile any medication the patient has. We know that medication reconciliation is a benefit of other MIH programs. With a provider in the home, the patient's actual medications can be evaluated. Outdated and old dosage medications can be properly disposed of in order to prevent medication errors. If a patient had difficulty obtaining a new medication, the MIH provider can immediately identify this potentially life threatening issue and seek solutions to obtain the medications. . In addition to the physical patient assessment and medication reconciliation, the MIH provider will also focus on the home and social services. Does the patient have family/community support? Are they in need of food or other needs? Further patient care and/or advise will be through the recommendation of the PCP/urgent care following the EMS assessment. When in doubt EMS will contact their Medical Director for further advice.

Staffing Plan

EMS agency name has identified X number of EMS providers who will be the MIH providers. These individuals will be available to conduct homecare visits X number of days a week. These providers will be located at insert address and will respond in insert vehicle type. Funding of these positions will be through 1135 Waiver when it becomes available.
Provide a list of provider and licensure level.

Training Plan

The initial training of the MIH providers will focus on appropriate personal protective equipment for providers and patient; advanced patient assessment, differential diagnosing who are our community partners. The training will focus on patient assessment findings that would require the patient to either see their PCP, urgent care or an emergency department versus what can be managed at home. This training will be conducted with the EMS agencies lead training officers and Medical Director.

Medical Direction

Medical direction for the MIH program will be provided jointly by two physicians; one of the providers will be an emergency room physician and the second will be a primary care physician. All medical direction for the program will be determined by jointly by the two physicians. In addition to medical direction, both of the medical directors will be involved in the quality management of the program. Below is a brief bio on each of the medical directors:

Insert bios here.

Quality Management

Any EMS MIH provider must be approved by the joint medical directors and EMS unit head. This approval will evaluate the completion of their education and performance of their competencies. All home visit will be evaluated by the EMS Unit leader to ensure that the MIH providers are adhering to the scope of the program. This information will be reported to the medical directors monthly.

Data Collection

The cornerstone of any good MIH program is data: collection, interpretation and utilization of that data to improve current processes. We will use the TEMSIS MIH form for the electronic document of the MIH patient encounters. The quality management team will have access to data gathering in TEMSIS and provide monthly reports based on predetermined data points.

Patient Care

- A. Perform an initial comprehensive history and physical assessment exam
- B. Perform an ongoing comprehensive longitudinal history and physical assessment exam
- C. Measure vital signs
- D. Administer breathing treatments
- E. Monitor wound care
- F. Monitor intravenous therapy
- G. Administer intravenous therapy
- H. Manage chronic disease (e.g., diabetes, asthma, COPD, coronary artery disease)
- I. Monitor chronic disease (e.g., diabetes, asthma, COPD, coronary artery disease)
- J. Administer point of care testing (e.g., glucose monitoring)
- K. Manage patient/client experiencing an acute medical condition
- L. Manage patient/client experiencing a transitional medical condition (e.g., post-operative care, hospital discharge, home health discharge, rehabilitation)
- M. Manage patient's status using laboratory values
- N. Manage patient's status using diagnostic tests (e.g., pulse oximetry, capnography)
- O. Assist with home mechanical ventilation (e.g., CPAP/BIPAP)
- P. Administer pharmacologic agents:
 - 1. Intravenous
 - 2. Intramuscular
 - 3. PO
 - 4. Subcutaneous
- Q. Educate about pharmacologic agents: transdermal
- R. Administer intranasal immunizations
- S. Manage patient with conditions related to the following systems:
 - 1. Appearance (e.g., fever, weight loss)
 - 2. Eyes
 - 3. Ears, Nose, Mouth, Throat
 - 4. Cardiovascular
 - 5. Respiratory
 - 6. Gastrointestinal
 - 7. Genitourinary
 - 8. Musculoskeletal
 - 9. Integumentary (skin and/or breast)
 - 10. Neurological
 - 11. Psychiatric
 - 12. Endocrine
 - 13. Hematologic/Lymphatic
 - 14. Allergic/Immunologic
- T. Perform minor medical procedures: Fluid replacement
- U. Maintain patient confidentiality (HIPAA)
- V. Prepare patient/client to navigate the healthcare system independently
- W. Communicate with patient/client to ensure continued care (e.g., medication adherence, follow-up care)

Preventative Care and Education

- A. Assess safety risks for the community paramedic (e.g., unsafe situations, animals, diseases)
- B. Assess safety risks for the patient/client (e.g., disease, falls, environmental health hazards)
- C. Assess the safety of the work environment
- D. Educate on proper use of healthcare resources

- E. Provide oral health education and/or screening
- F. Educate on identified healthcare goals
- G. Perform a physical safety inspection (e.g., home, property, vehicle)
- H. Screen for chronic disease (e.g., diabetes, asthma, Coronary Artery Disease)
- I. Differentiate injury patterns associated with specific mechanisms of injury (e.g., falls, elder abuse)
- J. Provide service with the local public health agency (e.g., immunization, disease investigation, TBDOT)
- K. Provide service with the local social service and aging agencies (e.g., adult protection, child protection, senior services, housing)
- L. Participate in wellness clinics (e.g., immunization and screening)
- M. Provide education for:
 - 1. chronic diseases
 - 2. medical conditions
 - 3. community resources
 - 4. wellness and nutrition
 - 5. medications
- N. Identify the impact that professional boundaries have on patient/client/family and provider health (e.g., ethics, compassion fatigue, stress)
- O. Apply coping methods to reduce stress