Academy of Medicine of Cincinnati
2027 Community Paramedicine / Mobile Integrated Healthcare
Clinical Practice Guidelines

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Medical Director Approval: _____ **Date:** _____

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This document was acknowledged before me, a Notary Public, this _____ day of _____, 20 _____

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Introduction

The Academy of Medicine of Cincinnati Clinical Practice Guidelines (Guidelines) have been designed not only to be practically applied but also to be used as a teaching tool. Where possible, evidence-based medicine (EBM) has been used to create the clinical care protocols you see in this document. When no formal EBM was applicable, a process of consensus building within the protocol committee was used to arrive at the final product. The concept of mobile integrated healthcare (MIH) is still new and rapidly changing.

There are several caveats in the protocol: These Guidelines do not cover all possible patient complaints. Make sure to do a thorough patient assessment and proceed to the appropriate Guideline. Remember that whenever there is any question regarding medical treatment, medical direction is available. The sections marked **EVAL** are the responsibility of all levels of providers. Sections listed as MONITOR are more advanced and involve potentially specific equipment. **TREAT** sections are for the most advanced level of intervention. These typically require specific equipment and medications. Medical directors elect a level, which would include the preceding level of care.

Medical directors must elect to what level their system will operate. By selecting the appropriate box below, the medical director has elected that throughout the protocol sections listed in that category are approved. Medical directors may also elect to only authorize certain protocols or differing levels. By selecting within each Guideline, the medical director can approve those Guidelines or specific levels.

As medical director of this agency, I have elected to permit throughout the protocol care at the marked level.

☐ **EVAL** ☐ **MONITOR** ☐ **TREAT** ☐ **PER INDIVIDUAL GUIDELINE**

These Guidelines are designed to supplement existing emergency guidelines and must be viewed with this in mind. Generic and Brand names of medications may be used interchangeably. Review patient allergies, if possible, prior to medication administration and do not administer any medications to which the patient has a true allergy.

Nationally there are shortages of medications. The State of Ohio will not allow the use of expired medications at the current time. Alternate medications that can be used can be found on the website. However, eventually there may be a situation where there is no substitute for a medication that is not available. In the current legal environment if you do not have a medication, then you cannot use it and must proceed with the protocol as best as possible. There is no intent that all listed medications must be carried.

These protocols are not standard operating procedures (SOP's). There are position statements from many other official agencies that can be used to augment these protocols.

Lastly, the purpose of these protocols is to establish guidelines between EMS administration, the EMS provider and medical direction for the evaluation, monitoring, and treatment of specific mobile integrated healthcare issues. The protocols are not designed nor intended to limit the EMS provider in the exercise of good judgment or initiative in taking reasonable action in extraordinary circumstances. These protocols are intended to assist in achieving excellent, consistent prehospital care for patients. The following protocols are not intended to provide a solution to every problem which may arise. We will achieve the high standard required of emergency medical services (EMS) only by coordinating our operations, working together, and maintaining a high degree of professionalism.

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These protocols can be found at the Academy of Medicine website.

Administrative

CP1	CP1: Community Paramedic Program Scope and Exclusion Criteria	CP1
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2027

EVAL

I. Purpose

A. To define the operational boundaries, inclusion criteria, and exclusion criteria for the Community Paramedicine (CP) / Mobile Integrated Healthcare (MIH) Program. This section ensures appropriate patient selection, safe care delivery, and clear delineation between CP services and traditional emergency medical services.

II. Program Scope

A. The Community Paramedicine Program provides non-emergent, patient-centered care in the home or community setting under the direction of the EMS medical director and in coordination with the patient's healthcare team.

B. Core Functions

1. The CP Program includes, but is not limited to:
   a. Comprehensive patient assessments (medical, functional, and environmental)
   b. Chronic disease monitoring and education (e.g., CHF, COPD, diabetes, hypertension)
   c. Medication reconciliation and adherence support
   d. Social Determinants of Health (SDOH) screening and resource navigation
   e. Post-discharge follow-up and care transition support
   f. Behavioral health screening and support
   g. Home safety evaluations
   h. Point-of-care testing and limited diagnostic services (per protocol)
   i. Telehealth facilitation with licensed providers
   j. Care coordination with primary care providers (PCPs), specialists, home health, hospice, and social services
   k. Select procedures and treatments as authorized by protocol and medical direction
2. These services are intended to:
   a. Reduce unnecessary 911 utilization and emergency department (ED) visits
   b. Improve patient compliance and outcomes
   c. Address care gaps, especially in high-risk populations
   d. Promote overall health, well-being, preventive health practices

C. Program Limitations

1. The CP Program:
   a. Does NOT replace:
      i. Primary care providers (PCP)
      ii. Home health agencies
      iii. Hospice or palliative care teams
      iv. Emergency medical response systems
   b. Does NOT function as:
      i. A primary emergency response unit
      ii. A long-term case management service without defined goals
      iii. An independent prescribing or treatment authority outside protocol
   c. All care must:
      i. Remain within Ohio scope of practice (Ohio Administrative Code 4765)
      ii. Follow approved protocols and medical direction
      iii. Be consistent with physician orders when applicable

III. Patient Inclusion Criteria

A. Patients may be eligible for CP/MIH services if they meet one or more of the following:

1. Clinical Criteria
   a. Chronic disease requiring monitoring or education (CHF, COPD, diabetes, etc.)
   b. Recent hospital discharge or high risk for readmission
   c. Medication mismanagement or adherence concerns

d. Wound care or post-procedural follow-up needs (within scope)

2. Utilization Criteria
   a. High EMS/911 utilization (e.g., ≥15 calls in 90 days)
   b. Frequent ED utilization for non-emergent conditions
   c. Identified by healthcare partners as high-risk or avoidable-utilization patients
3. Social / Functional Criteria
   a. Identified SDOH needs (housing, food, transportation, utilities)
   b. Limited access to healthcare or mobility barriers
   c. Need for care coordination or resource navigation
4. Program Participation Requirements
   a. Patient resides within service area
   b. Patient (or legal representative) has decision-making capacity
   c. Patient is willing to participate in the program
   d. Safe access to the residence is achievable for CP personnel

IV. Exclusion Criteria

A. Patients are NOT appropriate for CP management if any of the following are present:
1. Emergent Medical Conditions
   a. Any condition requiring immediate emergency evaluation or intervention
   b. Signs of unstable or life-threatening illness, including:
   c. Acute chest pain
   d. Respiratory distress
   e. Altered mental status
   f. Active stroke symptoms
   g. Uncontrolled bleeding
2. These patients must be referred to 911 EMS response and transported to the emergency department

B. Clinical / Operational Exclusions
1. Patient requires services outside CP scope (e.g., skilled nursing, continuous monitoring)
2. Complex medical management requiring direct physician oversight on-site
3. Active condition requiring hospital-level care

C. Behavioral / Safety Exclusions
1. Unsafe environment posing risk to CP personnel
2. Violence or credible threats
3. Hazardous living conditions
4. Patient unwilling to allow assessment, intervention, or follow-up
5. Repeated non-compliance that prevents safe or effective care

D. Programmatic Exclusions
1. Patient already receiving equivalent services from:
   a. Home health agencies (unless CP is requested for additional support)
   b. Hospice (unless CP personnel is specifically requested for support)
2. Lack of coordination with PCP or care team when required
3. Patient outside defined geographic service area

V. Escalation and Termination Criteria

A. Immediate Escalation (Terminate CP Encounter)
1. CP personnel will activate Law Enforcement or EMS and transition to emergency care if:
   a. Patient condition becomes unstable or emergent
   b. New high-risk symptoms are identified
   c. CP personnel determines continued care in home setting is unsafe

VI. Program Discharge Criteria

A. Patients may be discharged from the CP Program when:
   1. Goals of care have been achieved
   2. Patient demonstrates ability to self-manage
   3. Patient transitions to appropriate long-term services
   4. Patient declines further participation
   5. Patient no longer meets inclusion criteria

VII. Medical Oversight and Authority

A. All care is performed under the authority of the EMS Medical Director

B. CP personnel must:
   1. Follow established protocols
   2. Seek medical direction when required
   3. CPs personnel shall not independently initiate or modify treatment plans outside:
      a. Standing orders
      b. Physician-directed care

VIII. Guiding Principle

A. When there is uncertainty regarding patient stability, appropriateness for home-based care, or safety of continued evaluation, the default action is to escalate care and utilize emergency medical services.

CP2	CP2: Community Paramedic Program Referrals	CP2
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2027
EVAL	**I. PURPOSE:** To assist the primary care provider (PCP), EMS provider, medical provider, or social worker with an automatic referral process to ensure the patients are enrolled and receive proper CP home/place of residence visit(s). The community paramedic (CP) will provide encounters for patients upon referrals. **II. PROCEDURE:** 1. Referrals will be sent to the CP office via email, or other electronic transfer from the ordering providers, EMS provider, or social worker. Direct phone calls are acceptable when necessary. 2. The referral form (depending on what system is used) will include: Patient's name; Date of birth; Contact information; the patient's emergency contact information; diagnosis; reason for CP visit; medical provider information. 3. The CP personnel may access the patient's history and physical assessments, visit notes, lab results, and list of current medications through the hospitals' electronic health record (EHR), if available. If not, the CP personnel may request a copy or summary of the patient's record from the medical provider or referring agent. 4. If the referral is non-traditional and the service request does not fall clearly under an existing protocol, or is not within known program parameters, a case consult will be initiated. 5. If the patient self-refers, the CP personnel will discuss care with the patients' normal provider team prior to initiating care. 6. If the patient does not have a primary care provider, the CP personnel will assist the patient in obtaining a PCP. If immediate care is needed, the CP personnel can utilize online medical direction for advice.	

CP3	CP3: Community Paramedic Education Program	CP3
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2026
EVAL	**I. PURPOSE:** The Community Paramedic (CP) Education is designed to equip EMT's and paramedics with the advanced knowledge and clinical skills necessary to deliver high-quality care in non-emergent, community-based settings. The curriculum ensures that CP personnel can understand and execute a wide range of assessments, referrals, and interventions. **II. PROCEDURE:** 1. Paramedics who are certified by the International Board of Specialty Certifications (IBSC) at the Community Paramedic (CP-C) level, and/or have graduated from programs accredited by the Global Community Paramedic Higher Education Council (GCPHEC), are considered having completed the medical portions of the Community Paramedic Curriculum. These paramedics will still need orientation on the administrative aspects of the program. 2. Education Curriculum — the classroom portion covers expanded patient assessment; process to conduct well-person checks, patient assessments, health screenings, home safety evaluations, medication compliance, and referral programs. Please see APPENDIX. 3. Care and support for hospice/terminally ill patients — CP personnel will learn to assess and support patients and families during end-of-life care. 4. Homebound Patients with Special Challenges — focus on patients with limited mobility or access to medical care. 5. Psychiatric and Behavioral Health Assessment — includes evaluation of psychiatric and behavioral conditions, acute alcohol withdrawal, and depression screening. 6. Instruction and Oversight — education provided by a multidisciplinary team including medical director, director of EMS, physicians, community health coordinators, community paramedics, registered nurses, paramedic instructors, advanced practice nurses, physician assistants, and specialty care nurses. Curriculum periodically reviewed and approved by the medical director. 7. Student Evaluation — each CP student will be regularly evaluated. Continuing education includes regular case reviews with the community health coordinator, EMS director, or medical director and other medical staff.	
MONITOR	8. Identification and CP management of chronic diseases including COPD/asthma, CHF, diabetes, hypertension, kidney disease/dialysis, neuropathy, Alzheimer's/dementia, decubitus ulcers, skin/foot/wound care. 9. Non-Emergent Complaint Assessment — CPs will evaluate and manage nausea/vomiting, upper respiratory infections, tooth pain. Medication Familiarity — identify commonly prescribed medications, understand indications, side effects, and potential interactions. 10. Clinical Experience — hands-on rotations in emergency department (chronic care emphasis), hospice, CHF clinic, home/wound care, case management, diabetes education, mobile coach/street medicine, inpatient CHF, acute MI outpatient follow-up, stroke outpatient follow-up. 11. Laboratory – hands on orientation to use of point-of-care (POC) tests available, sample collection, basic results interpretation.	
TREAT	12. Orientation to treatment algorithms in specified protocols.	

CP4	CP4: Social Determinants of Health Screening and Resource Assistance Programs	CP4
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2026

EVAL

I. PURPOSE:

To identify social and environmental factors that may impact the patient's health, safety, and overall well-being. This screening supports early recognition of unmet needs — such as housing stability, access to food, transportation, utilities, social support, and home safety — and guides timely referrals to appropriate community resources. It may be completed during any visit to assess changes in circumstances or emerging risks.

II. PROCEDURE:

1. Obtain and review patient's history and physician(s) orders prior to appointment.
2. Review patient's information with the patient, including medical/medication history.
3. Use motivational interviewing techniques to assess the patient's general wellbeing in the home and make sure all their basic needs are met.
4. Complete the Accountable Health Communities Health-Related Social Needs Screening Tool.
5. Complete any additional SDOH Screening Tools, deemed necessary.
6. Assess such necessities as adequate food, cleanliness, clothing, shelter, companionship, supportive social network, ability or access to transportation, financial ability to pay bills, activities of daily living (ADLs), and other important day-to-day needs.
7. Determine needs and potential eligibility for health care and/or social support. Attempt to assist completing applications or referrals and provide follow-up information as indicated.
8. Document all referrals and communicate list and current health concerns to primary physicians or appropriate social entities.
9. Contact referring physician or agency if CP personnel or patient has concerns.
10. Determine if follow up is needed with physician and/or social service.
11. If any life-threatening issues are identified, notify the proper resource immediately.

CP5	CP5: Home Safety Assessment	CP5
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2027
EVAL	**I. PURPOSE:** To ensure the home is in safe condition to meet the medical needs of the patient. It can be used to conduct a pre-surgical assessment, post-operative assessment, or an evaluation of the safety of the home at any time. **II. PROCEDURE:** 1. Complete the Home Safety Inspection. 2. Complete comments on any sections marked "No" during the inspection. 3. Complete recommendations for the resident and appropriate referrals. 4. Discuss the findings with the resident. 5. Connect resident with necessary resources. 6. Document the findings including any discussions and/or explanations of the assessment with the resident and/or caregiver. 7. If any life-threatening issues are identified, notify the proper resource immediately. 8. Following report completion, forward a copy to the primary care provider (PCP).	

CP6	CP6: High EMS/9-1-1 Utilizer/High Utilizer Group	CP6
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2026

EVAL

I. **PURPOSE:**

CP personnel may help patients successfully navigate the health care system by preventing unnecessary transport to the emergency department by employing the use of the CP protocols, and any medical direction provided by the appropriate medical provider. A patient may also be "flagged" in a 9-1-1 program, adding the CP team to the dispatched assignment when available.

II. Referral Criteria:

1. High Utilizer Group (HUG) patients may include those who meet the following criteria.
    a. Has requested 15 or more 911 ambulance responses in the past 90 days **-OR-**
    b. Referred by a partner agency for avoidable visits to the ED during the past 12 months **-OR-**
    c. Administration requests addition of the patient to the HUG program.

    -AND-

    d. Live in the CP service area
    e. possess mental capacity to support navigational assistance
    f. willing to participate in the program and allow the CP team into their home for assessment and follow up.

III. **PROCEDURE:**

1. Follow General Protocol for CP Patient Assessments.
2. Consider adding the patient's HUG status to the premise history in the computer-aided dispatch system for possible co-response of the CP team on 911 calls.
3. Educate the patient and the patient's family on ways to manage their health care needs.
4. Assess the patient for referral or enrollment in healthcare and community-based programs to address the patient's clinical, social, and/or behavioral health needs. This may include medication compliance; healthy lifestyle changes; nutritional support; home environment/safety needs; behavioral health support.
5. Educate the patient and/or family members on how to utilize the local primary/specialty care network to help manage their medical needs. This includes who & when to call for an appointment; how to call for an appointment; important information to share with healthcare providers; how to access transportation services.
6. Unscheduled Home Visits: The patient may be provided with a non-emergency access number for the CP program. This gives the patient an opportunity for a telephonic consultation or a home visit before the next scheduled CP visit.
7. The primary care provider (PCP) for these patients remains the primary contact for care coordination. If the PCP is not available and immediate assistance is needed, contact medical control. The PCP may request activation of other CP/MIH protocols in advance of an anticipated need.
8. The patients will be enrolled in the program for a minimum of 30 days, and a maximum of 90 days, based on compliance and meeting goals. The medical director, sometimes in conjunction with the PCP, may authorize further extensions of the program if needed.

CP7	CP7: Medical Direction	CP7
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2026
EVAL	**I. PURPOSE:** The community paramedic (CP) will follow physician orders outlining care so much as it is within the Ohio EMS scope of practice cited in the Ohio Administrative Code Chapter 4765 and applicable regulations, applicable emergent (911) clinical practice guidelines Community Paramedicine Clinical Practice Guidelines , and report directly through verbal or written dialogue with the patient's primary physician. Any case in which the patient's life and/or limb may be in danger during the duration of the encounter should result in a request for the appropriate resources. **II. PROCEDURE:** 1. All community paramedics (CP) will work within the full capacity of their current education and authorized scope of practice. This is done under the EMS agency medical director(s); and more specifically, the CP program. 2. The CP personnel will follow medical provider orders and administer care within the current education and scope of practice. 3. The CP personnel reports directly through verbal or written dialogue with the patient's ordering and primary physician(s). If additional medical needs are identified during a CP visit, the following will occur based on the urgency of care needed: 4. If an emergent medical need is identified, the CP personnel will request appropriate resources. The CP personnel encounter will immediately end, and the CP personnel will act as a first responder until appropriate resources arrive. The CP personnel will accompany the patient during transport if appropriate. 5. If there are any medical needs that do not require immediate transport to a hospital, however, the CP personnel feels the patient should be seen urgently in a medical provider's office, the CP will: first attempt to contact the patient's primary medical provider or other pre-established providers. The second attempt will be to contact the medical director of the agency or of the Community Paramedic program. Third attempt will contact online medical control.	

CP8	CP8: Scheduled Patient Encounters	CP8
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2027

EVAL

I. **PURPOSE:**

To standardize the components of scheduled CP patient encounters. The community paramedic (CP) will respond to the CP patient location, on order or request to conduct a home/place of residence visit.

II. **PROCEDURE:**

1. Types of scheduled patient encounters: (1) initial consultation; (2) comprehensive needs assessment; (3) follow-up evaluation(s) — progress of continuity of care, education, program status change/update.
2. Initial consultation: Following a CP Program referral, this consultation will include an overview of the CP Program, a brief screening of the patient's needs, and determination of next steps (schedule a comprehensive needs assessment or conclude that no further CP involvement is necessary). This may be completed in person or via telephone.
3. Comprehensive needs assessment: Scheduled encounters typically at the patient's home/place of residence, including history and assessment/screening; home safety assessment; home medication education and reconciliation; SDOH assessment and resource assistance programs; patient discharge.
4. General follow-up: Obtain and review patient history and physician(s) orders prior to the appointment; follow the physician orders/discharge pamphlets; obtain vital signs; discuss ideal recovery plan and current response to treatment; communicate unusual findings to the corresponding medical providers.
5. Post-injury follow-up: Review discharge instructions; assess the patient's pain control and understanding of recommended medications; assess the patient's limited mobility; assess injury site for inflammation or infection.
6. Discharge from the Community Paramedic Program: CP patients should remain enrolled until a resolution is reached. Possible outcomes include patient referred to appropriate resource provider; patient demonstrated ability to independently perform ADLs; patient declines continued CP services. Patients will be notified of discharge from the program.

CP9	CP9: Documentation of Patient Care	CP9
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2027
EVAL	**I. PURPOSE:** All patient encounters or communications regarding a patient's care or healthcare/social needs will be documented. This provides guidance for documentation of patient care, whether face-to-face, telephonically, or via other electronic means (e.g. email or fax). This includes communication with family members, other care providers, social service organizations, or any other person/entity involved in a CP patient's care. **II. PROCEDURE:** 1. Face-to-face encounters — first visit: reason for call; referral source; vital signs; medication inventory; home safety assessment; SDOH assessment; disease-specific assessments; narrative following SOAP format or equivalent; referrals made; disposition encouraged to include date and time of next visit. 2. Follow-up visits: reason for visit; vital signs; updated medication inventory; progress of plan, referrals, or continuity of care; disease-specific reassessment; narrative following SOAP format or equivalent; disposition including date and time of next visit. 3. Non-face-to-face encounters (e.g., phone calls, face-to-face conversation with family members/other healthcare providers): pertinent summary of encounters. 4. Paper/Electronic Documents: Archive in the electronic patient care report (ePCR).	

CP10	CP10: Medical Equipment Assistance	CP10
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2026
EVAL	**I. PURPOSE:** To assist the patient in ensuring efficacy of personal medical equipment. A patient with a pre-existing medical device or drug administration is typically not covered in the paramedic training or scope of practice. The community paramedic (CP) will respond to the patient location to assist the patient in determining the course of action regarding the proper usage of personal medical equipment. This will be done through knowledge of patient history and contacting appropriate resources. **II. PROCEDURE:** 1. Obtain and review patient history and, if applicable, any orders prior to appointment. 2. Utilize the following appropriate resources: the patient themselves; the patient's family; online medical control; other patient care staff such as MD, RN, LPN, CNA, etc.; any other individual who has been trained in the specific care of the patient (i.e. day care worker). 3. Take all reasonable steps to support existing medical care and support the best outcome for the patient within the scope of practice. 4. If necessary, have patient transported to the appropriate facility based on patient's particular situation. 5. Document the visit and notify the physician's office, if applicable. 6. Determine if follow up is needed.	

EVAL

I. **PURPOSE:**

To assist the patient in non-life intervening measures as written in the hospice care plan. To provide the patient and care giver with comfort and education as to the patient's disease process, focusing on signs or symptoms to expect. To ensure that the patient's wishes and requests are fulfilled. To intervene as necessary; when signs and symptoms are not indicative of the terminal disease process.

II. **PROCEDURE:**

1. Obtain and review the patient's health history and physician orders in the hospice care plan.
2. Communicate with the patient's hospice nurse or hospice nurse on call.
3. Review patient's information with the patient and/or care givers, including medical/medication history, current medications the patient is receiving and taking, adherence, time of doses, physician who prescribed medications and sources of medications (pharmacy).
4. Ask the patient if there are any medications they take which they do not want to disclose.
5. Obtain and trend (if applicable) the patient's vital signs.
6. Consult with the hospice nurse if patient current signs and symptoms are not within their normal status.
7. Provide appropriate treatment for the patient as per the hospice care plan, the hospice nurse, or online hospice medical direction.
8. Check the patient's medications to assure that the patient is taking them correctly or the family understands how to administer them correctly.
9. Continue to communicate with the hospice nurse until they arrive on scene.
10. If the family becomes adamant that the patient be transported to the emergency department, call for a transport unit.
11. Communicate all signs and symptoms, medication adherence problems, change in the patient normal status, or any other issues on scene that affect the patient's successful hospice/palliative care, with the patient hospice nurse or hospice provider.
12. Determine if follow up is needed.

CP12	CP12: Alternative Destination & Transport	CP12
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2027

EVAL

I. PURPOSE:

To assess the patient who might be appropriate for alternative transport or an alternative destination. This guideline provides general guidance for patients who may be transported to a destination other than a hospital emergency department when appropriate, under the Community Paramedicine Program.

II. PROCEDURE:

1. Follow medical and comprehensive needs assessment guidelines.
2. Obtain and review patient health history and primary care provider's orders prior to evaluation when available.
3. Follow the appropriate CP protocols for the patient's complaint.
4. Contact the PCP or on-line medical direction per the guidelines and provide patient report and discuss treatment and continuity plans.
5. Continue treatment and follow the guidelines until a disposition is determined, and a continuity plan is completed.
6. Patients found to be suffering from an acute medical emergency will be transported by an EMS vehicle dispatched to a hospital-based emergency department.
7. A patient may be transported to an alternative non-emergency facility via a non-emergency vehicle, such as a doctor's office or clinic, provided that the patient, family or on-line medical direction requests/suggests the alternative destination and the patient is clearly stable, and it has been determined that an emergency no longer exists.
8. Alternative Transportation CP Directive: For a patient for whom an emergency does not exist and for whom an evaluation or scheduled visit at a doctor's office, clinic or other alternative destination is desired, an alternative form of transport may be considered. Transport options might include a private car, taxi, wheelchair van, or other non-emergency medical transport vehicle.

Adult Guidelines

CP13	CP13: Asthma Management	CP13
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2027
EVAL	I. **PURPOSE:** To assist the patient (family/caregiver) by increasing awareness of the disease through education on pathology of asthma. To demonstrate and review techniques of all devices used to treat asthma. To evaluate and identify home triggers of disease to lessen exacerbations. II. **PROCEDURE:** 1. Obtain and review the patient's health history and physician(s) orders prior to appointment; including plan for diet, exercise, and medication dosages. 2. Follow physician orders. 3. Obtain and trend (if applicable) the patient's vital signs. 4. Review pathophysiology with patient including signs and symptoms of disorder and corrective actions. 5. Record the current patient history including frequency of symptoms at rest, with activity and with sleep. Further history will include exacerbating factors including virus exposure, aeroallergen exposure, exercise, cold air, tobacco smoke, chemical irritants, etc. 6. Observe home to possibly identify exacerbating factors. 7. Educate patient in use of spirometer. 8. Review additional devices used by the patient including short/long-acting medications and MDI/continuous nebulizer devices. 9. Connect patient with necessary resources. 10. Determine if follow up is needed.	
TREAT	11. If immediate treatment is needed, follow SB202 Symptom Based Respiratory Distress and other relevant protocols.	

CP14	CP14: Chronic Congestive Heart Failure (CHF)	CP14
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2027

EVAL

I. **PURPOSE:**

To assist the patient (family/caregiver) by increasing awareness of the disease through education on pathology of CHF. To evaluate and identify home triggers of the disease to decrease exacerbations.

II. **PROCEDURE:**

1. Obtain and review the patient's health history and physician(s) orders prior to appointment, including plan for diet, exercise, and medication dosages.
2. Obtain and trend (if applicable) the patient's vital signs.
3. Review the pathophysiology with patient including signs and symptoms of disorder and corrective actions.
4. Record the current patient history including recent exacerbations of dyspnea, orthopnea, paroxysmal nocturnal dyspnea, cough or weight gain.
5. Obtain history of medication adherence; complete a medication review and obtain history of salt and fluid intake.
6. Obtain weight and orthostatic blood pressure (BP) along with general physical examination.
7. Educate patient on medication(s); specifically, the use of diuretics as it relates to increasing weight gain and fatigue.
8. Review the patient's level of dyspnea when performing activities of daily living in home.
9. Observe compliance with telemetry monitoring for heart failure if present.
10. Connect the patient to necessary resources.
11. Determine if follow up is needed.

MONITOR

12. Utilize lab testing if appropriate; BMP/BNP/magnesium, or as otherwise directed.

III. Management Protocol

1. If a POC blood analyzer available, or if lab results are <1 week old:
    a. If the potassium is <2.5 or >5.5 mEq/L, arrange for transportation to the emergency department or consult another appropriate provider for alternative plan.
    b. If creatinine is >3 mg/dL, consult appropriate provider for follow-up appointment within 24-48 hours.

-NEXT PAGE-

TREAT

1. **Diuresis and Potassium Dosing**

Green Zone	Yellow Zone	Red Zone
Patient does NOT have: Shortness of breath Swelling Weight gain Chest pain Decrease in daily activity	**Patient HAS any of the following:** Gained 2-3 lbs. in one day or >5 lbs. in 1 week Increased cough Increased swelling Increased dyspnea on exertion Orthopnea Pulse oximetry 3 or more points lower than normal	**Patient HAS any of the following:** Chest pain for >15 minutes or not relieved by rest/nitro Sudden or severe chest pain Visible dyspnea Reported syncope New arrhythmia Coughing pink or white phlegm
CP personnel should encourage patient to: Continue treatment plan Record daily weight Avoid salt Keep physician appointments Exercise as prescribed by their medical provider	CP personnel should: Contact CHF clinic or cardiologist **Upon approval of patient's provider initiate the following Lasix and potassium dosing**	CP personnel should: Contact dispatch for EMS vehicle for patient stabilization and transportation to emergency department.

2. **Contraindications:**
   a. Weight gain of < 2 lbs. over baseline
   b. Potassium of < 2.5 mEq/L or > 5.5 mEq/L (transport or consult as appropriate)
   c. Acute clinical changes such as chest pain, dyspnea, signs of acute decompensation
   d. Any discomfort on the part of CP personnel or provider about the patient's clinical presentation

Diuresis Dosing Schedule:

2-3 lbs over	4-5 lbs over	>5 lbs over
Give 1.5x the patients' normal oral dose of furosemide (Lasix) or bumetanide (Bumex). CP follow up in 48 hours PCP notification PCP follow up in 96 hours Refer to potassium dosing below.	Double the patients' normal oral dose of furosemide (Lasix) or bumetanide (Bumex). for 3 days. CP follow up in 24 hours PCP notification PCP follow up within 48 hours Refer to potassium dosing below.	Administer double the patient's oral dose of furosemide (Lasix) as IVP x 1. (Bumetanide (Bumex) 1mg IVP is therapeutically equivalent to furosemide (Lasix) 40mg IVP) Refer to potassium dosing below. CP follow up (may be via phone) in 4 hours CP in person visit in 24 hours PCP follow up in 48 hours

Potassium Dosing Schedule:

K+ = 2.5-2.9 (mEq/L)	K+ = 3.0-3.4 (mEq/L)	K+ = 3.5-4.9 (mEq/L)	K+ ≥5.0 (mEq/L)
Increase by 50% for the length of time patient has increased Lasix dosing.	Increase by 25% for the length of time patient has increased Lasix dosing.	No change.	Refer to hyperkalemia protocol.

If diuresis is done more than 3 visits in a row, refer to an advanced heart failure clinic.

CP15	CP15: Chronic Kidney Disease	CP15
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2027
EVAL	I. **PURPOSE:** To assist the patient (family/caregiver) by increasing awareness of the disease through education on pathology of Kidney Failure. II. **PROCEDURE:** 1. Obtain and review the patient's health history and physician(s) orders prior to appointment; including plan for diet, exercise, and medication dosages. 2. Obtain and trend (if applicable) the patient's vital signs. 3. Review the pathophysiology with patient including signs and symptoms of disorder and corrective actions. 4. Record current patient history of dyspnea, orthopnea, paroxysmal nocturnal dyspnea, cough or weight gain. 5. Record current patient history of medication adherence and history of salt and fluid intake. 6. Record current patient history of weight, orthostatic blood pressure and nutritional status along with general physical examination. 7. Educate patient on medications; specifically, the use of diuretics, if still producing some urine, as it relates to increasing weight gain and fatigue. 8. Review the patient's fatigue with performance of activities of daily living at home. 9. Observe compliance with hemodialysis or peritoneal dialysis. 10. Connect the patient with necessary resources. 11. Determine if follow up is needed.	
MONITOR	12. Utilize lab testing if appropriate; BMP, magnesium and phosphorus.	

CP16	CP16: Chronic Obstructive Pulmonary Disease	CP16
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2027
EVAL	I. **PURPOSE:** To assist the patient (family/caregiver) by increasing awareness of the disease through education on pathology of COPD. To demonstrate and review the techniques of all devices used for the treatment of COPD. To evaluate any home triggers of the disease to decrease exacerbations. II. **PROCEDURE:** 1. Obtain and review the patient's health history and physician(s) orders prior to appointment; including plan for diet, exercise, and medication dosages. 2. Obtain and trend (if applicable) the patient's vital signs. 3. Review the pathophysiology with the patient including signs and symptoms of disorder and corrective actions. 4. Record current patient history including symptoms at rest, with activity and sleep. Changes in sputum color and tenacity and any recent exacerbating factors such as viral URI, smoking, allergens, cold air, etc. 5. Educate the patient on the use of peak flow meter and pulse oximetry. 6. Check home for any exacerbating factors, i.e. inadequate ventilation of heating system, lack of air conditioning (A/C) in the humid months. 7. Review devices/MDI/nebulizers with the patient. Have the patient demonstrate capability of using the devices correctly. 8. Review medications for adherence and side effects. 9. Connect the patient with necessary resources. 10. Determine if follow up is needed.	
TREAT	11. If immediate treatment is needed, follow SB202 Symptom Based Respiratory Distress and other relevant protocols.	

CP17	CP17: Diabetes Management	CP17
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2027

EVAL

I. **PURPOSE:**

To ensure the proper maintenance of blood sugar and insulin levels in the diabetic patient. This will be accomplished through blood glucose monitoring, appropriate prescription drug usage, recognition of desired drug effects, further education, and/or additional resources.

II. **PROCEDURE:**

1. Obtain and review the patient's health history and physician's orders prior to appointment; including plan for diet, exercise, and medication dosages.
2. Obtain and trend (if applicable) the patient's vital signs.
3. Review the pathophysiology with the patient including signs and symptoms of disorder and corrective actions.
4. Complete a detailed history and physical exam.
5. Observe the patient's physical state and general well-being.
6. Obtain blood glucose level (BGL) and compare with home glucometer.
7. Note directions for insulin/medication administration and record compliance.
8. Note and record compliance with diet and exercise plan.
9. Note and record the patient's concerns about the treatment plan (insulin levels, blood sugar levels).
10. Document and follow-up with the patient's physician if a significant increase or decrease in patient's normal BGL level.
11. Connect the patient with necessary resources.
12. Determine if follow up is needed.

MONITOR

13. Obtain POC Hgb A1c if it has been >1 year since last record.
14. If indicated, obtain basic metabolic panel (BMP), and urinalysis via POC or Lab testing.
15. If the patient is using a continuous glucose monitor (CGM), ensure that the patient understands how to remove it and apply a new device.
16. If they are using a combination CGM and insulin and/or glucagon pump, ensure that the patient understands how to pair the new CGM to the pump, how to refill the pump, how to troubleshoot and operate the pump, and when/how to replace the infusion sites.
17. If the patient is using a standalone insulin pump, ensure the patient knows how to refill the pump, how to troubleshoot and operate the pump, and when/how to replace the infusion sites.

TREAT

III. **Treatment**

1. Refer to M406 Hyper/Hypoglycemia for immediate treatment options if needed.
2. If the patient’s blood glucose is >500 mg/dL (or “HIGH”) or POC BMP CO2 level is <20 mmol/L, encourage emergency department evaluation.
3. If the patients’ blood glucose is >250 mg/dL but <500 mg/dL (or “HIGH”) consider administering one 500 mL IV bolus of 0.9% NS.
4. If the patient has PCP instructions on how to handle high readings, assist the patient with carrying out those instructions. This may include assisting in the administration of insulin. Contact the PCP’s office to arrange evaluation and for further instructions.
5. If the patient does not have PCP instructions, attempt to discuss the patient with the PCP for further instructions.
6. Recheck the patient’s blood glucose following IVF bolus. If insulin has been administered, recheck blood glucose at 60 minutes. If it has trended downward, and patient is otherwise asymptomatic, consider the patient for a possible “treat and release”. If the blood glucose has not gone down, or if the patient is symptomatic, encourage transportation to the ED.

CP18	CP18: Hypertension Management	CP18
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2027

EVAL

I. **PURPOSE:**

To ensure the proper maintenance of hypertensive patient and their adherence with medications, diet, and exercise. This will be accomplished through blood pressure monitoring, appropriate prescription drug usage, recognition of desired drug effects, and further education/resources.

II. **PROCEDURE:**

1. Obtain and review the patient's health history and physician(s) orders prior to appointment; including plan for diet, exercise, and medication dosages.
2. Obtain and trend (if applicable) the patient's vital signs; obtain manual and/or automated blood pressure readings.
3. Assess home BP equipment for accuracy.
4. Review pathology with patient including signs and symptoms of disorder and corrective actions.
5. Observe the patient's physical state and general well-being.
6. Determine whether the patient has additional symptoms which may be related to their elevated blood pressure such as chest pain, shortness of breath, other pain, headache, or neurological symptoms. Symptomatic patients should be considered for transport to the emergency department for evaluation.
7. Note directions for medication administration and record adherence.
8. Note diet and exercise.
9. Note and record patient's concerns about treatment plan (varying BP readings).
10. Connect the patient with necessary resources.
11. Determine when follow up is needed.

MONITOR

12. Asymptomatic hypertensive patients are appropriate for home treatment and close follow up. Blood pressures with systolic below 220 mmHg and diastolic below 120 mmHg may be appropriate for home treatment.

TREAT

13. If the patient has written instructions on home treatment of asymptomatic hypertension breakthroughs, CP personnel may assist the patient in following those instructions.
14. Contact medical direction or the PCP for additional guidance.
15. Reminder that our goal in treating asymptomatic hypertension is to have the blood pressure decreased, and not to getting the BP normal. The goal is for no more than a 20% reduction in pressures.

CP19	CP19: Medication Adherence	CP19
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2027
EVAL	**I. PURPOSE:** To assist the patient in proper usage of home medications through information/education and vital sign checks. To assist the ordering physician in thorough documentation of all prescription and non-prescription medications, from all sources, for the purpose of avoiding adverse reactions due to drug omissions, duplications, drug-drug and drug-disease interactions and other errors due to miscommunication and/or misinterpretation. To ensure proper continuum of care during physician/health care provider transitions. **II. PROCEDURE:** 1. Obtain and review the patient's health history and physician(s) orders prior to appointment; including plan for lifestyle change and medication usage. 2. Obtain and trend (if applicable) the patient's vital signs. 3. Review the patient's information with the patient, including medical/medication history, current medications the patient is receiving and taking, adherence, time of doses, physician who prescribed medications and sources of medications (pharmacy). 4. Ask the patient if there are any medications they take which they do not want to disclose. 5. Assist the patient in sorting medications. 6. Stress the importance of medication adherence. 7. Document all medications whether prescription or otherwise and communicate the list and current health/reactions to primary physician. This should include dietary supplements. 8. Connect the patient with necessary resources. 9. Contact referring physician if CP personnel or the patient has concerns. 10. Determine if follow up is needed.	

CP20	CP20: Mental Health, Behavioral Health, and Substance Use Disorder Management	CP20
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2026

EVAL

I. PURPOSE:

Note: The threshold for identifying a psychiatric emergency is based on the level of agitation, violence, or uncooperative behavior that poses a threat to self or others. Although most patients seen by a community paramedic may be unlikely to cross that threshold, the safety of any scene can deteriorate rapidly, and a patient's condition can change rapidly — certainly from visit to visit. As a community paramedic, you need to be alert to the signs of imminent behavioral change, even violence.

To ensure the proper maintenance of mental health patients and their adherence with medications. This will be accomplished through providing the patient with a safe environment, both physically and emotionally.

II. PROCEDURE:

1. Obtain and review the patient's health history, physical exam and physician orders prior to the CP appointment; including plan for lifestyle change and medication usage.
2. Observe the patient's physical state and general well-being.
3. Obtain and trend (if applicable) the patient's vital signs.
4. Review the pathophysiology with the patient including signs and symptoms of disorder and corrective actions.
5. Determine whether the patient has additional symptoms which may be related to their condition such as chest pain, shortness of breath, other pain or discomfort, headache, or neurological symptoms.
6. Determine through the patient interview if there are internal or external factors that exacerbate their condition.
7. Note any abnormal feelings the patient has experienced since being last seen by their physician or community paramedic (thoughts of suicide, hurting themselves or others, anxiety, depression).
8. Note directions for medication administration and record adherence.
9. Note and record the patient's concerns about treatment plan. Communicate the patient and community paramedic's concerns to the physician.
10. Assess the patient's ability to perform daily functions (clothe, bathe, eat or prepare meals, ambulate). If the patient has any concern, communicate with the primary physician to align the patient with community resources.
11. If the patient has a history of depression, perform the PHQ-9 Patient Depression Questionnaire and record results.
12. Screen for domestic violence.
13. Determine if follow up is needed.
14. Refer to M407 Psychiatric Protocol as needed.
15. If the patient appears to be in an acute mental health crisis, consider requesting a co-response from the county crisis team, and/or contact medical direction for additional guidance.

TREAT

III. Anxiolysis for CP/MIH

1. This section is for the community paramedic who has responded to the scene where the patient is suffering from an acute, emotional trauma where oral anxiolysis would be of benefit for the crisis and/or as a bridge to physician evaluation if symptoms persist.
2. Indications:
    a. Treatment of acute, severe emotional trauma
    b. Acute, severe anxiety provoked by emotional trauma
3. Contraindications:
    a. Patient is suspected to be intoxicated by alcohol or other sedative/hypnotic that may potentiate the effects of an oral benzodiazepine.
    b. Patient has altered mental status from baseline.

c. Patient has reached the level of needing more aggressive treatment per M408 Restraint Protocol.

4. Procedure:
   a. Obtain a complete set of vital signs, including blood glucose, prior to and following medication administration.
   b. Patient should be left with a sober adult who has been instructed on signs of over-sedation and to call 911 if the patient exhibits them. This adult is responsible for the patient for the next 6 hours after which observation can be discontinued.
   c. Administer lorazepam 1mg tablet by mouth.
   d. May repeat lorazepam dose after 10-15 minutes up to a total dose of 2mg.

CP21	CP21: Post Cerebrovascular Accident (CVA)	CP21
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2027
EVAL	I. **PURPOSE:** To ensure the proper maintenance of CVA patients and their adherence with medications, diet, and exercise. This will be accomplished through lifestyle change, vital sign monitoring, appropriate prescription drug usage, recognition of desired drug effects, and further education/resources. II. **PROCEDURE:** 1. Obtain and review the patient's health history and physician(s) orders prior to appointment; including plan for lifestyle change and medication usage. 2. Refer to discharge instructions. 3. Obtain and trend (if applicable) the patient's vital signs. 4. Review pathophysiology with the patient including signs and symptoms of disorder and corrective actions. 5. Observe the patient's physical state and general well-being. 6. Determine whether the patient has additional symptoms which may be related to their condition such as chest pain, shortness of breath, other pain or discomfort, headache, or neurological symptoms. *Symptomatic patients should be considered for transport to the emergency department for evaluation. 7. Note directions for medication administration and record adherence. 8. Note diet and exercise recommendations from physician and note any discrepancies or concerns the patient has in accomplishing their goals. 9. Note and record the patient's concerns about treatment plan (inability due to deficits). Communicate the patient and community P=paramedic concerns to the physician. 10. Assess the patient's ability to perform daily functions (clothe, bathe, eat or prepare meals, ambulate). If the patient has any concern, communicate with the primary physician to align the patient with community resources. 11. Determine if follow up is needed.	

CP22	CP22: Respiratory Management of Sleep Apnea	CP22
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2027
EVAL	**I. PURPOSE:** To assist in observing and documenting recently diagnosed/chronic sufferers of obstructive sleep apnea through written and/or verbal communication to ensure proper ventilation of the patient during sleep for the purpose of avoidance of long-term pathologic outcomes associated with obstructive sleep apnea (OSA). **II. PROCEDURE:** 1. Obtain and review the patient's health history and physician orders prior to the CP appointment. 2. Obtain and trend (if applicable) the patient's vital signs. 3. Conduct a patient assessment: necessary VS assessments in addition to pulse oximetry (SPO2) and end-tidal CO2 (ETCO2) and weight/body mass index (BMI); sleep habits (e.g. irregular work schedule); alcohol/recreational drug use; prescription drug use; additional patient complaints; quality of life and any noticeable changes after usage of devices for the treatment of OSA. 4. Troubleshoot if, necessary, to ensure proper fit of mask and use of machine as well as general condition of machine. 5. Connect the patient with necessary resources (oxygen supply company, etc.). 6. Determine if follow up is needed.	

CP23	CP23: Wound Check / Post-Operative Dressing Change	CP23
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2027

EVAL

I. PURPOSE:

To assist in attending to soft tissue injuries for the purpose of restoration of function through repair of injured tissue while minimizing risk of infection and cosmetic deformity. This will be accomplished through visual inspection, wound cleaning, dressing, and bandage change, and patient education.

II. PROCEDURE:

1. Obtain the patient history including the history of wound, medical illnesses (certain illnesses may delay wound healing and increase risk of infection), current vaccination status (Tdap) and physician's orders.
2. Obtain and trend (if applicable) the patient's vital signs.
3. Visually inspect dressings and wound: examine dressings for excess drainage; examine wounds for infection and delayed healing including increasing inflammation, purulent drainage, foul odor, palpable subcutaneous air, persistent pain, and fever; if needed, document wound images and report to providers with updated records.
4. If signs of infection, contact physician immediately for follow up.
5. If no signs of infection, clean and dress wound per physician orders and educate patient on the signs and symptoms of an infection and risk management.
6. Make sure the patient is up to date on vaccinations (tetanus/rabies) and if needed connect with appropriate resources.
7. Connect the patient with necessary resources.
8. Determine if follow up is needed.

MONITOR

9. If the patient is on a wound vac, ensure vacuum component is functional and record any visible settings.

TREAT

10. Community paramedics may only reinforce wound vac dressings and are not permitted to replace them. Wound vac dressings can only be removed after receiving orders from a physician.
11. Community paramedics are not permitted to replace wound packing material. If a community paramedic receives an order from a physician, and the packing is grossly visible, the packing may be removed.
12. Specialized dressings require additional training. If the community paramedic has received training, and has physician orders, the community paramedic may replace these dressings if able. These could include films, foams, or fibers. Specialized cream-based dressings may also be replaced after first removing the existing cream.
13. Wound irrigation and cleaning may be performed by the community paramedic if there are physician orders to do so.
14. Community paramedics may assist the patient in emptying an existing drain collection container. Community paramedics are not permitted to remove drains.

Pediatric Guidelines

CP24	CP24: Newborn Home Assessment	CP24
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2027
EVAL	**I. PURPOSE:** To assess the home for hazards relevant to the daily activities, development, and growth of the newborn. The home assessment is an attempt to prevent future injury, illness, or death. The goal is to visit the home between days 7-14 following birth. **II. PROCEDURE:** 1. Complete the Home Safety Inspection. 2. Complete comments on any sections marked "No" during the inspection. 3. Complete recommendations for the parent and advise of available resources. 4. Discuss the findings with the parent. 5. Connect parent/guardian with necessary resources. 6. Educate the parent/guardian on safe sleep habits and inspect the crib. 7. Have the parent sign off the report with the understanding that they were advised of recommendations. 8. Complete report and return to the CP newborn file. 9. If any life-threatening issues are identified, notify the community paramedic medical control. 10. References: Pediatric Home Safety Assessment Checklist.	
MONITOR	**III. Baby Evaluation** 1. Record the child's birth weight, original due date, APGAR scores, and whether there was a NICU stay following delivery. 2. Obtain vital signs on the infant. If able, this should include a weight. 3. Recommend transportation to the emergency department if the patients' temperature is >100.5° F, or if the patient has a heart rate >200 beats per minute that is persistent at rest without crying. 4. Calculate weight loss/gain from birth. 5. Consult PCP or medical control if the patient has lost >10% body weight since birth.	

CP25	CP25: Pediatric Asthma Management	CP25
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2027

EVAL

I. PURPOSE:

To assist the patient (family/caregiver) by increasing awareness of the disease through education on pathology. To demonstrate and review technique of all devices used to treat asthma. To evaluate and identify home triggers of disease to lessen exacerbations. To communicate with the primary physician on the general well-being of the patient as well as continuing medication adherence.

II. PROCEDURE:

1. Obtain and review the patient's health history and physician's orders prior to the CP appointment; including plan for diet, exercise, and medication dosages.
2. Follow physician orders.
3. Obtain and trend (if applicable) the patient's vital signs.
4. Review pathophysiology with patient and parent/guardian.
5. Record current patient history including frequency of symptoms at rest, with activity and with sleep. Further history will include exacerbating factors including virus exposure, aeroallergen exposure, exercise, cold air, tobacco smoke, chemical irritants, etc.
6. Auscultate breath sounds with recording stethoscope and log on patient's electronic medical record (EMR).
7. Educate patient in use of the peak flow meter, if applicable.
8. Review additional devices used by the patient including short/long-acting medications and metered-dose inhaler (MDI) and continuous nebulizer devices.
9. Observe home to possibly identify exacerbating factors.
10. Note and record patient/guardian's concerns about treatment plan.
11. Connect the patient with necessary resources.
12. Document the visit and notify the physician's office.
13. Discuss any exacerbation plans if available.
14. Determine if follow up needed with the physician and/or the community paramedic.
15. *Values determined and directed by local ordering physician. *Request ambulance response through 911 dispatch for any life-threatening signs or symptoms.

CP26	CP26: Pediatric Diabetic Education	CP26
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2027

EVAL

I. **PURPOSE:**

To ensure the proper maintenance of blood sugar and insulin levels in the diabetic. This will be accomplished through blood glucose monitoring, appropriate prescription drug usage, recognition of desired drug effects, and further education and/or additional resources.

II. **PROCEDURE:**

1. Obtain and review the patient's health history focusing on the point of diagnosis and physician's orders prior to appointment; including plan for diet, exercise, and medication dosages.
2. Follow physician orders.
3. Review pathology with the patient and the guardian including signs and symptoms of disorder and corrective actions.
4. Obtain vital signs for patient health trends.
5. Observe the patient's physical state and general well-being. Create a parameter for the patient's "norm".
6. Obtain blood glucose level (BGL) and compare with home glucometer. Provide a glucose chart if the patient/guardian does not have one on hand.
7. Note directions for insulin administration and record adherence.
8. Record adherence with all medications.
9. Note diet, education given on diet and resources shared to help with diet compliance.
10. Note and record the concerns of the patient and/or guardian about the treatment plan (insulin levels, blood sugar levels, diet).
11. Document the visit and notify physician office.
12. Determine if follow up is needed with physician and/or community paramedic.
13. *Values determined and directed by local ordering physician. *Request ambulance response through 911 dispatch for any life-threatening signs or symptoms.

MONITOR

14. If requested, obtain POC HgbA1c or perform lab draw for drop off.

CP27	CP27: Pediatric Seizure Management	CP27
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2027
MEDIC	I. **PURPOSE:** To ensure the proper maintenance of seizure medication, seizure-controlled diets, and environmental risk factors. This will be accomplished through strict medication regimens, dietary education, recognition of desired drug effects, seizure tracking, and further education/resources. II. **PROCEDURE:** 1. Obtain and review the patient's health history and the physician's orders prior to the CP appointment; including plan for diet, exercise, and medication dosages. 2. Follow physician orders. 3. Review pathology with the patient and the guardian including signs and symptoms of disorder and corrective actions. 4. Obtain vital signs for patient health trends. 5. Observe the patient's physical state and general well-being. 6. Obtain, specifically, blood glucose level (BGL), temperature, seizure tracking data, and vital signs. 7. Note directions for any medication prescribed and note adherence. 8. Note diet. 9. Note and record the concerns of the patient and guardian about the treatment plan. 10. Note any changes in the patient's mobility and sensory reflexes. 11. Document the visit and notify the physician's office. 12. Determine if follow up is needed with physician and/or the community paramedic. 13. *Values determined and directed by local ordering physician. *Request ambulance response through 911 dispatch for any life-threatening signs and symptoms.
MONITOR	14. If requested by the physician, obtain lab draw for drop off. This may include special draws that require specific tubes. Please verify with the lab which color vials are needed.

Procedures

CP28	CP28: Non-Emergent Diagnostic EKG	CP28
Last Modified: 2026	Academy of Medicine of Cincinnati Community Paramedicine Practice Guidelines	2027
MONITOR	**I. PURPOSE:** To allow community paramedics to perform non-emergent diagnostic (e.g. 12 lead or 15 lead) EKGs outside of the usual 911 setting and when the appropriate equipment is available. **II. Indications:** 1. Order received from a physician. 2. Patient is asymptomatic and does not feel acutely ill. **III. PROCEDURE:** 1. The community paramedic will respond to the patient's location at the scheduled appointment time after receiving a referral from the patient's physician. 2. After the EKG is obtained, the EKG will be sent to the physician (transmitted when appropriate or indicated by the requesting physician). A notification will be sent to the ordering physician for review. 3. If the patient requires acute medical intervention, the community paramedic will call for a 911 ALS unit to respond to the scene. The community paramedic will revert from their CP medical guidelines and treat the patient according to EMS medical guidelines. When the 911 ALS unit arrives, patient care shall be transferred to the transporting paramedic. If transport is refused by the patient, then the responding ambulance crew is to initiate the standard transport refusal protocol, and document as such.	

CP29	CP29: Anticoagulation Therapy	CP29
Last Modified: 2026	Academy of Medicine of Cincinnati EMS Protocols Community Paramedicine	2027
MONITOR	**I.** Purpose: a. To assist the patient with ongoing anticoagulation therapy management in the home or community setting. b. This protocol outlines appropriate prescription drug use, education about side effects and POC INR monitoring when appropriate. **II.** Protocol a. Obtain appropriate referral for service. b. Review the patient's health history and medical provider's orders prior to evaluation by the CP team. c. Review the patient's prior history, indications for anticoagulation, contraindications, and conduct a physical exam. d. Observe the patient's physical state, general wellbeing, and any affected SDOH needs. e. Review relevant educational materials with the patient on their medication.	
EVAL	f. If the patient is on warfarin/coumadin, obtain a POC INR test and compare with prior results. g. If the patient was recently started on enoxaparin (Lovenox), obtain a POC diagnostic study that assesses renal function. h. Report lab testing to the referring provider. i. If a patient's INR is >5, or the patient is having signs or symptoms consistent with uncontrolled bleeding, activate the emergency response protocol. The patient should be evaluated in the emergency department unless a specific plan from the referring provider is in place. j. If the patient's INR is >4 or <2, the community paramedic should report these findings to the referring provider by the end of the day. k. If the patient's INR is above the patient's target INR, discuss the findings with the referring provider or medical direction. l. Community paramedics do not independently adjust the dosage of a patient's medication. Direct orders from a physician are required.	

CP30	CP30: Home Health Care Facilitation	CP30
Last Modified: 2026	Academy of Medicine of Cincinnati EMS Protocols Prehospital Care Clinical Practice Guidelines	2027
EVAL	**I. PURPOSE** A. To supplement home health care when home health care is indicated but is either not available or has not yet started. B. The community paramedic does not function as a home health care provider but instead responds to urgent referrals to help support the patient until home health care can take over. **II.** Protocol A. The community paramedic should receive a referral from either a provider, home health agency, hospital, or hospice services. This referral should stipulate the requested services, with a defined timeline on the length of those temporary services. B. Not all programs will operate 24/7/365, nor will all participate in this gap filling measure. C. The community paramedic should coordinate care amongst the various home health providers. D. If the patient does not have a primary care provider, the community paramedic will assist the patient in establishing care. This PCP will be the overseeing physician for home health care. Prior to establishing care, the EMS medical director may temporarily assume this role. E. A standard intake into the community paramedicine program should occur. F. The community paramedic may utilize telehealth in addition to in person visits to evaluate acute medical issues when appropriate. G. If the patient is not adhering to the recommendations for in person evaluation, the community paramedic should attempt to arrange transportation to either an urgent care or an emergency department, as deemed appropriate.	
MONITOR	H. The community paramedic may obtain diagnostic samples for testing when ordered by the provider. These may include POC diagnostic tests.	

CP31	CP31: Lab Draw / Phlebotomy Procedure	CP31
Last Modified: 2026	Academy of Medicine of Cincinnati EMS Protocols Prehospital Care Clinical Practice Guidelines	2027
MONITOR	**I. PURPOSE** A. To permit the community paramedic to obtain lab specimens for appropriate diagnostic testing. **II.** Protocol A. Community paramedic should verify the orders received for the lab visit. B. Using the appropriate technique, perform the lab draw or sample collection. C. If the community paramedic is unable to obtain venous samples after two attempts, discontinue further attempts. Discuss the next steps with the referring provider. D. Blood tubes must be collected in a specific order: red, green, purple, pink, blue. E. Each tube must be labeled according to the lab's requirements. The required documentation on the label generally is the: patient name, DOB, provider initials, date and time of lab draw. The specimens must be labeled at the time of acquisition. F. There may be lab paperwork required that is provided by the provider's office or hospital. G. Place samples in a lab biohazard bag. H. Protect specimens from temperature extremes and excessive physical agitation. I. Some specimens require special handling; follow the appropriate collection guidelines.	

CP32	CP32: Point of Care (POC) Lab Testing	CP32
Last Modified: 2026	Academy of Medicine of Cincinnati EMS Protocols Prehospital Care Clinical Practice Guidelines	2027
EVAL	**I. PURPOSE** A. To assist the medical provider in obtaining certain lab values while in the patient's home. B. Examples of POC tests that may be obtained in the home are: 1. Complete blood count (CBC) 2. Basic metabolic panel (BMP) 3. Renal function (GFR, Cr) 4. Blood glucose 5. Hemoglobin A1c (HgbA1c) 6. Urine dip stick 7. Influenza 8. COVID 9. Urine ketones 10. Urine pregnancy C. This protocol supplements the individual protocols where these lab tests may be referenced. Not every program will have all these tests available. D. In general, all these lab tests require a CLIA waiver and routine test confirmations/calibrations. E. Refer to the following documents available online: 1. CLIA Quality Assessment Plan 2. CLIA General Policies and Procedures Manual 3. CLIA EPOC and Waived Testing Procedures Manual 4. CLIA EPOC Testing Personnel Plan 5. EPOC Supplies Logbook F. Programs opting to use point-of-care labs should have procedures specifically on the requirements of the selected tests.	

CP33	CP33: Suture/Staple Removal	CP33
Last Modified: 2026	Academy of Medicine of Cincinnati EMS Protocols Prehospital Care Clinical Practice Guidelines	2027
EVAL	**I. PURPOSE** A. To carry out suture/staple removal in a healed wound, as directed by a physician. **II.** Procedure A. Visually assess the wound for signs of complete closure. There should not be any evidence of dehiscence, wound complications, infection, redness, or swelling. B. Document the number of sutures or staples visible. C. CP personnel may clean the area as per normal wound care. D. Mattress or running continuous sutures are not eligible for removal.	
TREAT	E. Simple Interrupted Suture Removal: 1. Clean the wound prior to removing the sutures. 2. Using a suture removal kit, gently grasp the knot with forceps and slightly raise it off the skin. 3. Placed the curved tip of the scissors under the knot or side, close to the skin. 4. Snip the suture and remove it with forceps. Never snip both sides of the knot. 5. Ensure all suture material is removed and placed on gauze. 6. Remove every second suture (every-other) until the end of the wound. 7. If signs of dehiscence, listed below, develop stop and contact either the physician responsible for the sutures or medical control. 8. If there are no signs of dehiscence, continue removal until all sutures are removed. 9. Any sutures not able to be removed should be left intact, and the patient referred to the physician who placed the sutures or their PCP. F. Staple Removal: 1. Clean the wound prior to removing the staples. 2. Using a staple remover, place the lower jaw (2 prongs) underneath the staple with the upper jaw (1 prong) on top of the staple. 3. Squeeze the handle to close the device causing the staple to bend in the middle removing it from the skin. 4. Remove the staple from the area and release it into gauze. **Staples are considered sharps and should be disposed of in a sharp's container.** 5. Remove every second (every other) staple until the end of the wound. 6. If signs of dehiscence develop, stop and contact either the physician responsible for the staples or medical direction. 7. If there are no signs of dehiscence, continue removal until all staples are removed. 8. Any staples not able to be removed should be left intact, and the patient referred to the physician who placed the staples or their PCP. G. Post-Removal Care: 1. Clean and dry the wound. 2. Apply sterile wound strips to reduce likelihood of dehiscence. 3. Advise patient on signs of infection and need for continued wound care until healed. H. Wound Dehiscence Care: 1. Discontinue suture or staple removal. 2. Cover wound with saline moistened gauze. 3. Contact referring physician or medical direction for guidance.	

CP34	CP34: Telehealth Facilitation	CP34
Last Modified: 2026	Academy of Medicine of Cincinnati EMS Protocols Prehospital Care Clinical Practice Guidelines	2027
EVAL	**I. PURPOSE** A. To expand access to care for patients as needed and as indicated per provider order. B. To perform clinical assessments and interventions ordered and outlined under the paramedic scope of practice. **II.** Protocol A. Telehealth visits in general should be arranged prior to the scheduled appointment. B. In certain circumstances, the community paramedic may be able to arrange an unscheduled telehealth consultation with a provider. C. All platforms used to facilitate the encounter must be HIPAA compliant. D. Ensure a quiet well-lit environment. E. Ensure there is a strong internet connection on the device used. F. Obtain verbal consent from the patient prior to initiating the telehealth visit. G. In general, discretion is advised when performing examinations on camera. Avoid unnecessarily disrobing the patient and examining sensitive areas. H. Prior to initiating the visit, obtain baseline vital signs and conduct a routine physical exam. I. It is the responsibility of the supervising provider to inform the patient about any potential costs associated with the use of a telehealth visit. J. Ensure that any orders received from the provider are documented and initiated if applicable.	

CP35	CP35: Urinary Catheters and Urinary Complaints	CP35
Last Modified: 2026	Academy of Medicine of Cincinnati EMS Protocols Prehospital Care Clinical Practice Guidelines	2027

EVAL

I. PURPOSE

A. To assess complaints related to the urinary tract.

B. To assess, repair, replace, or place urinary catheters and their associated components.

II. Protocol

A. Obtain and review the patient's health history and primary care provider's orders prior to evaluation when possible.

B. Obtain a urine sample for possible testing.

1. Urine samples should be collected by mid-stream clean catch directly into a specimen cup.
2. Alternatively, a sterile "hat" may be placed over a toilet to collect urine, however these have a much higher rate of contamination.
3. Samples may be obtained directly from some urinary catheter systems. Verify with the supervising provider prior to obtaining these samples. In-dwelling catheters are frequently colonized with bacteria. Unless the patient has urinary symptoms, obtaining these specimens, including urine cultures, are likely to be of little diagnostic benefit.

TREAT

C. Place a urinary catheter if ordered.

1. Community paramedics may place urinary catheters under the "added competencies" of the Ohio EMS scope of practice. The medical director must ensure that all CP personnel credentialed for this skill have been adequately trained.
2. Follow standard technique for the placement of the urinary catheter type.
3. Consider the use of 2% lidocaine jelly to ease discomfort during catheter placement.
4. Ensure that the collection bag is placed below the level of the catheter to prevent retrograde urinary flow.

D. Evaluate a malfunctioning catheter.

1. Ensure that the catheter is still attached to the collection system.
2. Ensure that the in-dwelling balloon is still inflated.
3. Verify that there is no evidence of urinary leak, bleeding, or other discharge from the urethra.
4. If the catheter is not actively draining and there is concern for possible blockage, discuss further options with the PCP or medical direction.
5. If ordered to do so, the community paramedic may flush a urinary catheter with sterile saline to dislodge debris.
6. In some cases, the community paramedic may have placed a triple-lumen catheter for continuous bladder irrigation. If ordered, the community paramedic may establish continuous bladder irrigation of sterile saline for a reasonable amount of time. This may facilitate breakup of debris or clot material.
7. Ensure that during irrigation the patient is not developing lower abdominal pain or distention. If this occurs, discontinue the irrigation attempt and contact either the PCP or medical direction.

E. Replace a catheter

1. When needed, a community paramedic may replace a urinary catheter using the information in section "C" above.
2. Before removing the existing catheter, it is important to deflate the balloon and ensure it was removed intact.

Forms

CP36: EMS COMMUNITY PARAMEDICINE REFERRAL SCREEN

Patient: _____ **DOB:** _____ **Date:** _____

Run #: _____ **Unit:** _____

REFERRAL INDICATORS ***(Check all that apply)***

UTILIZATION / ACCESS
- ☐ Frequent 911 Use
- ☐ Frequent ED Visits
- ☐ Recent Hospital Discharge
- ☐ No PCP
- ☐ Missed Appointments

MEDICAL
- ☐ CHF
- ☐ COPD/Asthma
- ☐ Diabetes
- ☐ Hypertension
- ☐ CKD/Dialysis
- ☐ Medication Issues
- ☐ Wound Care Needs

BEHAVIORAL HEALTH
- ☐ Depression Concern
- ☐ Behavioral Health Concern
- ☐ Substance Use Concern

FUNCTIONAL / SAFETY
- ☐ Fall Risk
- ☐ Mobility Limitation
- ☐ Home Safety Concern
- ☐ Hoarding/Clutter
- ☐ ADL Assistance Needed
- ☐ Caregiver Support Needed

SOCIAL DETERMINANTS
- ☐ Food Insecurity
- ☐ Transportation Issues
- ☐ Housing Concern
- ☐ Utility Concern
- ☐ Financial Hardship
- ☐ Social Isolation

REFERRAL TRIGGERS
- ☐ Patient Requests Help
- ☐ Family Requests Follow-Up
- ☐ EMS Provider Concern
- ☐ Other: _____

REFERRAL PRIORITY
- ☐ Routine (≤7 Days)
- ☐ Priority (≤72 Hours)
- ☐ Post-Discharge (≤48 Hours)
- ☐ High Risk (Same-Day Review)

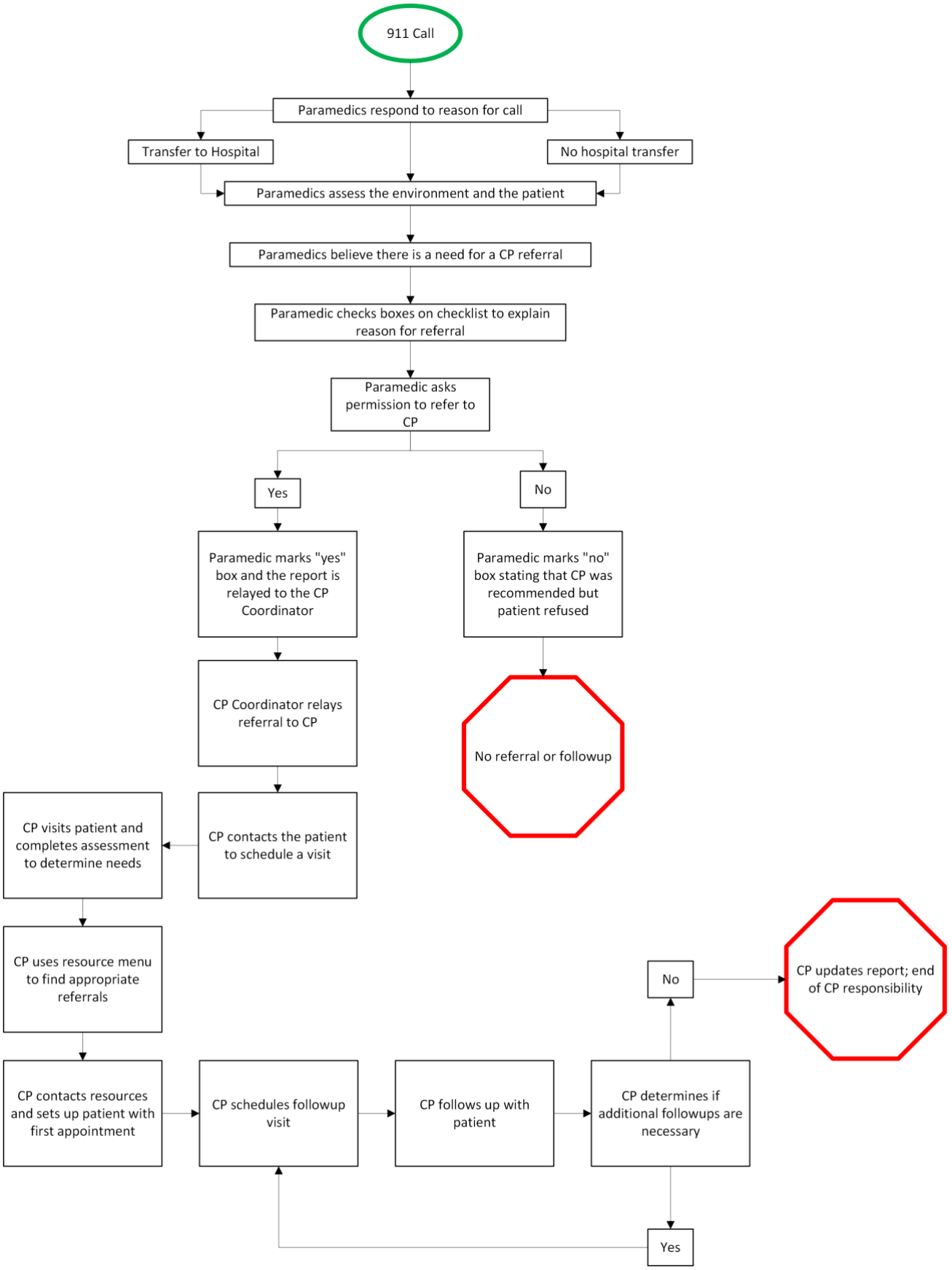
DISPOSITION
- ☐ Refer to Community Paramedicine
- ☐ Discuss with CP Coordinator
- ☐ No Referral

Patient Aware of Referral:
☐ Yes ☐ No ☐ Unable

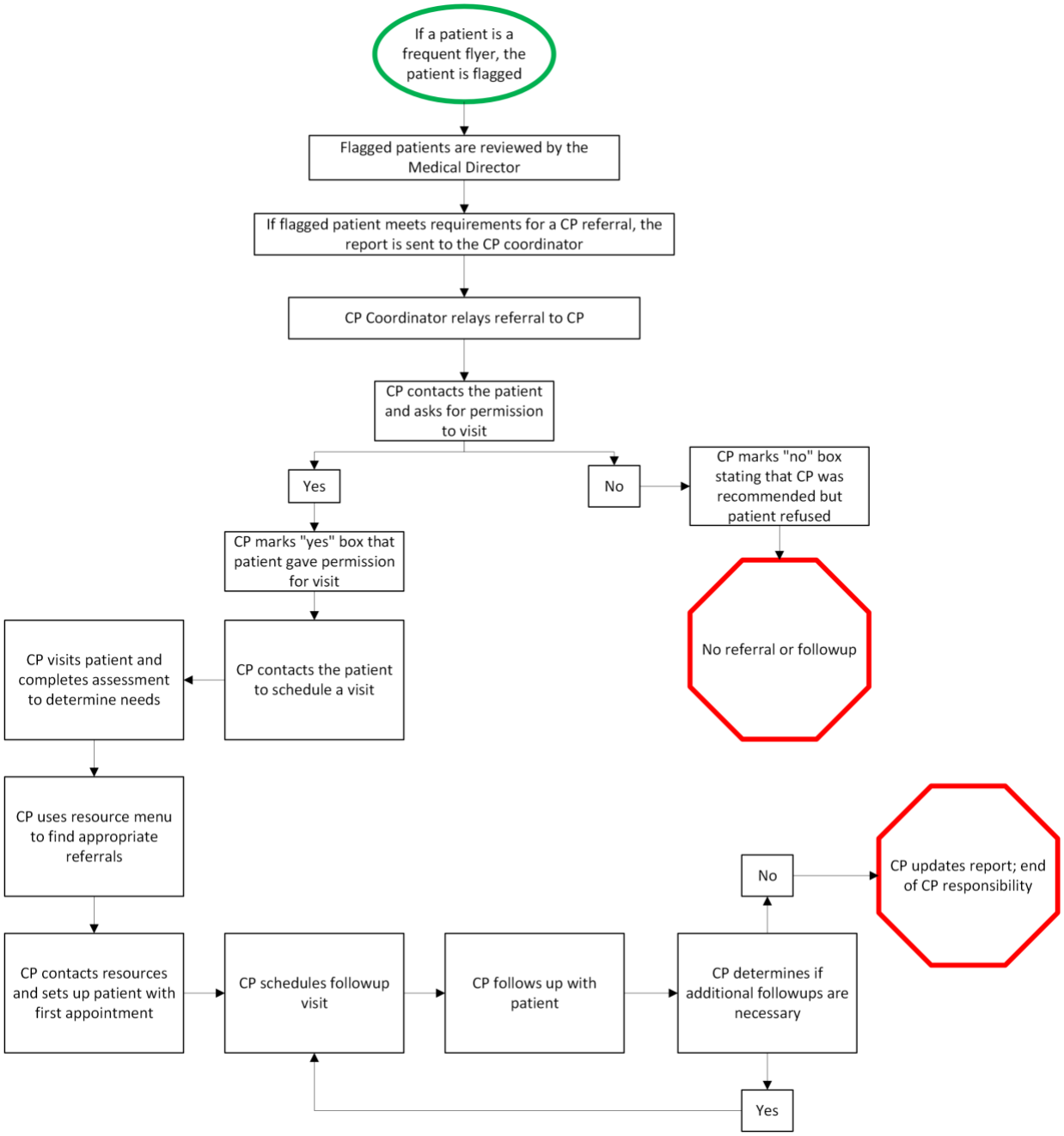
COMMENTS:

Crew Member: _____ **CP Referral Submitted:** ☐ **Yes** ☐ **No**

CP37: Program Entry Pathway 1



CP38: Program Entry Pathway 2



CP39: ACH Tier 1

Patient Information

Name: _____ **DOB:** _____

Date: _____ **CP Visit Type:** ☐ Intake ☐ Follow-Up ☐ post-discharge

◈ TIER 1 — CORE AHC SCREEN (10 Questions)

Housing Instability

1. What is your living situation today?

- ☐ I have a steady place to live
- ☐ I have a place to live today, but I am worried about losing it in the future
- ☐ I do not have a steady place to live

1a. Think about the place you live. Do you have any problems with any of the following?
(Check all that apply)

- ☐ Pests such as bugs, ants, or mice
- ☐ Mold
- ☐ Lead paint or pipes
- ☐ Inadequate heat
- ☐ Oven or stove not working
- ☐ Smoke detectors missing or not working
- ☐ Water leaks
- ☐ None of the above

Food Insecurity

2. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- ☐ Often true ☐ Sometimes true ☐ Never true

3. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

- ☐ Often true ☐ Sometimes true ☐ Never true

Transportation

4. In the past 12 months, has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living?

- ☐ Yes – medical care/medications
- ☐ Yes – non-medical needs
- ☐ No

Utilities

5. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?

- ☐ Yes ☐ No ☐ Already shut off

Interpersonal Safety

6. How often do you feel physically and emotionally safe where you currently live?

- ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

7. In the past 12 months, has anyone hit, kicked, punched, or otherwise hurt you?

- ☐ Yes ☐ No

8. In the past 12 months, has anyone insulted, talked down to you, or threatened you with harm?

- ☐ Yes ☐ No

9. In the past 12 months, has anyone screamed or cursed at you, or made you feel afraid?

- ☐ Yes ☐ No

Assistance Acceptance

10. If we find that you have needs related to any of these areas, would you like help connecting to resources today?

- ☐ Yes ☐ No

Tier 1 Positive Domains

☐ Housing

☐ Food

☐ Transportation

☐ Utilities

☐ Safety

Source

Centers for Medicare & Medicaid Services (CMS). *Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool* (2018).

CP40: ACH Tier 2

Patient Information

Name: _____ **DOB:** _____

Date: _____ **CP Visit Type:** ☐ Intake ☐ Follow-Up ☐ Post-Discharge

◈ TIER 2 — SUPPLEMENTAL AHC DOMAINS (11 Questions)

Recommended for CP enrollment, follow-ups, or positive Tier 1 screens Financial Strain

11. How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

- ☐ Very hard ☐ Somewhat hard ☐ Not hard at all

Employment

12. Do you have a job?

- ☐ Yes ☐ No ☐ Retired / Disabled

13. If no, are you currently looking for work?

- ☐ Yes ☐ No

Family & Social Support

14. If for any reason you need help with active daily living such as bathing, preparing meals, shopping, managing finances, etc., Do you get the help you need?

- ☐ No Help ☐ Get all the Help I need ☐ I could use a little Help ☐ I could use a lot of Help

15. How often do you see or talk to people you care about and feel close to?

- ☐ Less than weekly ☐ 1–2 times weekly ☐ 3+ times weekly

Physical Activity

16. In a typical week, how many days do you engage in moderate or strenuous exercise?

- ☐ 0 ☐ 1–2 ☐ 3–4 ☐ 5+

Substance Use

17. How often do you drink alcohol?

- ☐ Never ☐ Monthly ☐ Weekly ☐ Daily or almost daily

18. In the past year, have you used recreational drugs or misused prescription medications?

- ☐ Yes ☐ No

Mental Health

19. Over the past two weeks, how often have you felt down, depressed, or hopeless?

- ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

20. Over the past two weeks, how often have you felt nervous, anxious, or on edge?

- ☐ Not at all ☐ Several days ☐ More than half the days ☐ Nearly every day

Disabilities

21. Do you have serious difficulty seeing, hearing, walking, climbing stairs, dressing, bathing, or doing errands alone?

- ☐ Yes ☐ No

Tier 2 Identified Needs

☐ Financial
☐ Employment
☐ Mental Health
☐ Substance Use
☐ Disability
☐ Social Isolation

Actions Taken

☐ Education Provided
☐ Warm Handoff / Referral
☐ APS / COA Notified
☐ Follow-Up Visit Scheduled

Notes:

Source

Centers for Medicare & Medicaid Services (CMS). *Accountable Health Communities (AHC) Health-Related Social Needs Screening Tool* (2018).

CP41: NIH Stroke Scale

National Institutes of Health Stroke Scale (NIHSS)		Score
Instructions	Scale Definition Date/Time	Baseline
1a. LOC	0 = **Alert** keenly responsive I = **Not Alert** but arousable by minor stimulation to obey, answer, respond 2 = **Not Alert;** requires repeat stimulation, obtunded, requires strong stimuli 3 = **Reflex motor** or autonomic effects response, totally unresponsive, flaccid	
1b. LOC Questions. Ask the patient the month & age	0 = **Answers both** questions correctly I = **Answers one** question correctly 2 = **Answers neither** question correctly	
1c. LOC Commands. Ask to open & close eyes, then grip & release with non-paretic hand.	0 = **Performs both** tasks correctly I = **Performs one** task correctly 2 = **Performs neither** task correctly	
2. Best Gaze. Asked to follow with eyes thru horizontal plane (or oculocephalic maneuver).	**0=Normal** I = **Partial Gaze Palsy;** gaze is abnormal in one or both eyes but forced deviation or total gaze paresis is not present. 2 = **Forced deviation;** total gaze paresis not overcome by oculocephalic man.	
3. Visual fields (quadrants) tested with finger counting or visual threat. (done by confrontation)	0 = **No** visual loss 1 = **Partial** hemianopia 2 = **Complete** hemianopia 3 = **Bilateral** hemianopia (including cortical blindness).	
4. Facial Palsy. Asked to show teeth & raise eyebrows	0 = **Normal** symmetrical movement I = **Minor paralysis** (flattened nasolabial fold, asymmetry on smiling) 2 = **Partial paralysis** (total or near total paralysis of lower face) 3 = **Complete paralysis** of one or both sides (no upper/lower face mvmt).	
5. Motor Arm. Asked **to** extend arms (palm down) 90° (if sitting) or 45° (if supine) & hold for I0 seconds. Begin with non-paretic limb.	0 = **No drift;** limb holds 90° (or 45°) for full 10 seconds 1 = **Drift,** limb holds 90° (or 45°) but drifts down before full I0 seconds but does not hit bed or other support 2 = **Some effort against gravity,** limb cannot get to or maintain (if cued 90°or 45°) drifts down to bed but has some effort against gravity. 3 = **No effort against gravity,** limb falls 4 = **No movement** *UN= Amputation, joint fusion: Explain_____	**Left:** Right:
6. Motor Leg. While supine, asked to hold leg at 30° for 5 seconds.	0 = **No drift;** leg holds 30° for full 5 seconds 1 = **Drift**, leg falls but does not hit bed 2 = **Some effort against gravity,** falls to bed w/in 5 sec 3 = **No effort against gravity;** leg falls to bed immediately 4 = **No movement** *UN= Amputation, joint fusion: Explain_____	**Left:** Right:
7.Limb Ataxia. Finger - nose & heel - shin test on both sides	0 = **Absent** 1 = **Present in one** limb 2 = **Present in two** limbs *UN= Amputation, joint fusion: Explain_____	
8. Sensory. Sensation or grimace to pin prick or withdrawal from noxious stimuli to limbs in obtunded or aphasic patient.	0 = **Normal,** no sensory loss 1 = **Mild/moderate** sensory loss; may be dulled/"Not as sharp" 2 = **Severe/total** sensory loss; not aware of face/arm/leg being touched.	
9.Best Language. Describe what is happening in picture, name items of figures, read list of sentences on attached figures.	0 = **No aphasia,** normal 1 = **Mild / moderate aphasia;** some loss of fluency / comprehension, without limitation of expression of ideas. (can identify what is happening in picture) 2 = **Severe aphasia;** (cannot identify pictures) 3 = **Mute;** global aphasia; no usable speech; or auditory comprehension	
10.Dysarthria. Read or repeat words from list.	0 = **Normal** articulation I =**Mild/ Moderate;** slurs some words; understood w/some difficulty. 2 = **Severe**, so slurred as to be unintelligible; mute/anarthric *UN= Intubated or other physical barrier. Explain_____	
11.Extinction & Inattention. Look at visual (from #3) and double simultaneous tactile. Do both arms & legs.	0 = **No** abnormality 1 = **Visual, tactile, auditory, spatial or personal inattention** or extinction to bilateral stimulation in one sensory modality. 2 = **Profound hemi-inattention** or inattention to more than one modality; does not recognize own hand; orients to only one side of space.	
*UN= untestable		**TOTAL SCORE**

CP42: Home Safety Assessment

Date of Visit:			
Occupant Name:			
Outside of House			
1. Sidewalk and/or pathway to house is level and free from any hazards.	YES	NO	N/A
2. Driveway is free from debris/snow/ice.	YES	NO	N/A
3. Outside stairs are stable and have sturdy handrails.	YES	NO	N/A
4. Porch lights are working and provide adequate lighting.	YES	NO	N/A
Living Room			
1. Furniture is of adequate height and offers arm rests that assist in getting up and down.	YES	NO	N/A
2. Floor is free from any clutter that creates tripping hazards.	YES	NO	N/A
3. All cords are secured in a manner that does not cause trip hazards.	YES	NO	N/A
4. All rugs are secured to floor with double-sided tape.	YES	NO	N/A
5. Lighting is adequate to light room.	YES	NO	N/A
6. All lighting has an easily accessible on/off switch.	YES	NO	N/A
7. Phone is readily accessible near favorite seating areas.	YES	NO	N/A
Kitchen			
1. Items used most often are within easy reach on low shelves.	YES	NO	N/A
2. Step stool is present, sturdy, and has a handrail.	YES	NO	N/A
3. Floor mats are non-slip tread and secured to floor.	YES	NO	N/A
4. Oven controls are within easy reach.	YES	NO	N/A
5. Kitchen lighting is adequate and easy to reach switches.	YES	NO	N/A
6. ABC fire extinguisher is in the kitchen.	YES	NO	N/A
Stairs			
1. Carpet is properly secured to stairs and/or all wood is properly secured.	YES	NO	N/A
2. Handrail is present and sturdy.	YES	NO	N/A
3. Stairs are free from any clutter.	YES	NO	N/A
4. Stairway is adequately lit.	YES	NO	N/A
Bathroom	YES	NO	N/A
1. Tub and shower have a non-slip surface.	YES	NO	N/A
2. Tub and/or shower have a grab bar for stability.	YES	NO	N/A
3. Toilet has a raised seat.	YES	NO	N/A
4. Grab bar is attached near toilet for assistance.	YES	NO	N/A
5. Pathway from bedroom to bathroom is free of clutter and well-lit for ease of movement.	YES	NO	N/A
Bedroom			
1. Floor is free from clutter.	YES	NO	N/A
2. Light is near bed and is easy to turn on.	YES	NO	N/A
3. Phone is next to the bed and within easy reach.	YES	NO	N/A
4. Flashlight is near bed in case of emergency.	YES	NO	N/A
General			
1. Smoke detectors in all areas of the house (each floor) and tested.	YES	NO	N/A
2. CO detectors on each floor of the house and tested.	YES	NO	N/A
3. Flashlights are handy throughout the home.	YES	NO	N/A
4. Resident has all medical information readily available and is easy to find.	YES	NO	N/A
5. All heaters are away from any type of flammable material.	YES	NO	N/A
6. Are there any issues or hazards to having oxygen in the home?	YES	NO	N/A
7. Are there any issues or hazards to having pets in the home?	YES	NO	N/A
Overall Tips			
1. Homeowner has good non-skid shoes to move around the house.	YES	NO	N/A
2. All assisted walking devices are readily accessible and in good condition.	YES	NO	N/A

3. All oxygen tubing is less than 50ft. and is not a trip hazard.	YES	NO	N/A
4. Resident has had an annual hearing and vision check by a physician.	YES	NO	N/A
5. Resident has proper hearing and visual aids prescribed and are in good working order.	YES	NO	N/A
6. All medications are properly stored and labeled to avoid confusion on dosage and time.	YES	NO	N/A

Notes:

Recommendations for “NO” responses:

Referrals:

Signature of Resident: _____

Signature of Community Paramedic: _____

CP43: PHQ-9

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

CP44: Program Enrollment Consent

EXAMPLE

Patient Name: _____ DOB: _____Phone:_____
Address:_____

Enrollment Consent

I voluntarily agree to participate in the [AGENCY NAME] Community Paramedicine Program. I understand that program services may include health assessments, chronic disease monitoring, education, medication review, home safety evaluations, care coordination, telehealth facilitation, follow-up visits, and community resource referrals.

I understand that Community Paramedicine services do not replace emergency medical services, primary care, specialty care, home health, hospice, or behavioral health services. Participation is voluntary and may be discontinued by me at any time.

Authorization

By signing below, I authorize Community Paramedicine personnel to:

☐ Collect, document, maintain, and use health information necessary to provide Community Paramedicine services.

☐ Communicate and exchange relevant information with my physicians, hospitals, pharmacies, specialists, home health agencies, behavioral health providers, and other healthcare providers involved in my care.

☐ Coordinate services and share relevant information with approved community organizations assisting with healthcare, housing, transportation, food access, utility assistance, caregiver support, public health, and other identified needs.

☐ Contact me regarding Community Paramedicine services by telephone, voicemail, text message, email, mail, or other reasonable means.

Telehealth / Photography / Clinical Images

☐ I consent to participation in telephone, video, or other approved telehealth encounters when appropriate.

Initials: _____

☐ I authorize photographs or clinical images of wounds, medications, home safety concerns, or other clinically relevant findings for documentation, care coordination, consultation, treatment planning, and quality improvement.

Initials: _____

Patient Acknowledgement

I understand that:

☐ Participation is voluntary.

☐ My information will be protected in accordance with HIPAA and applicable privacy laws.

☐ I may withdraw from the program at any time.

☐ Questions regarding the program have been answered to my satisfaction.

☐ This authorization remains valid during program participation unless revoked in writing.

Patient / Legal Representative: _____
Relationship (if applicable): _____
Signature: _____ **Date:** _____

CP45: Referral Information for Healthcare & Community Partners

Program Overview

The Community Paramedicine Program provides non-emergency, home and community-based services designed to improve patient outcomes, support care transitions, address barriers to care, and connect individuals with healthcare and community resources. Community Paramedics work under physician oversight and collaborate with healthcare providers, hospitals, behavioral health professionals, social service agencies, and community organizations to support patients whose needs extend beyond a traditional office or emergency department encounter.

Program Objectives

- Reduce preventable 911 utilization
- Reduce avoidable Emergency Department visits
- Support successful post-discharge recovery
- Improve chronic disease management and medication adherence
- Address health-related social needs and barriers to care
- Improve coordination between healthcare and community resources
- Promote safe, independent living whenever possible

Appropriate Referral Candidates

Recent hospitalization or readmission risk

- Frequent EMS or Emergency Department utilization
- Chronic disease management needs
- Medication management concerns
- Fall risk or home safety concerns
- Transportation, food, housing, or utility barriers
- Social isolation or limited support systems
- Behavioral health concerns
- Difficulty navigating healthcare or community resources
- Need for additional care coordination

Referral Process

1. Complete the attached CP37 Referral & Authorization Form
2. Obtain patient authorization whenever possible
3. Submit referral to the Community Paramedicine Program
4. Program staff review the referral and contact the patient
5. Eligible patients may be offered enrollment and ongoing Community Paramedicine services

Referral Contact Information

Community Paramedicine Program

Coordinator: _____

Phone: _____Fax: _____

Email: _____Secure Referral Method: _____

Program Notice

Community Paramedicine services are non-emergency and are intended to supplement, not replace, primary care, specialty care, home health, hospice, behavioral health services, or emergency medical services.

CP45: COMMUNITY PARAMEDICINE REFERRAL & AUTHORIZATION

Patient Information
Patient Name: _____ **DOB:** _____
Phone: _____**Address:** _____

Emergency Contact: _____ **Phone:** _____

Referral Organization: _____
Referring Person: _____
Date: _____
Phone: _____

☐ Hospital ☐ Emergency Department ☐ PCP
☐ Home Health ☐ Hospice ☐ APS ☐ COA
☐ Behavioral Health ☐ Social Service Agency
☐ Other: _____

Referral Reason: Check all applicable concerns

	Medical / Utilization		Social / Environmental
☐	Recent Hospital Discharge	☐	Food Insecurity
☐	Readmission Risk	☐	Transportation Barriers
☐	Frequent ED Visits / 911 Utilization	☐	Housing Concerns
☐	Chronic Disease Management / Wound Care	☐	Utility Assistance
☐	Medication Concerns	☐	Financial Hardship
☐	Fall Risk	☐	Social Isolation
Behavioral Health		☐	Home Safety Concerns
☐	Depression / Anxiety Concerns	☐	Caregiver Support Needs
☐	Substance Use Concerns	☐	No Primary Care Provider
☐	Behavioral Health Support Needed	☐	

Brief Referral Summary

Patient Authorization

I authorize **[AGENCY NAME]** Community Paramedicine personnel to contact me and review information provided by the referring organization to determine eligibility for Community Paramedicine services. Participation is voluntary and may be declined at any time. I authorize the use and exchange of relevant information for eligibility review, care coordination, referral management, and service planning. Information may be shared with healthcare providers involved in my care and approved community agencies assisting with identified healthcare or social needs.

Patient Aware of Referral: ☐ Yes ☐ No
Patient Consents to Contact: ☐ Yes ☐ No

Patient / Legal Representative: _____
Relationship (if applicable): _____
Signature: _____**Date:** _____
If signed by a legal representative, I certify that I have authority to act on behalf of the patient.

Program Notice: This form authorizes referral review, outreach, eligibility determination, and care coordination activities only. Patients accepted into the Community Paramedicine Program may be asked to complete a separate Enrollment Consent (CP44) before receiving ongoing services.