Mobile Integrated Health (MIH)

Acute Illness or Injury Follow Up

CENTRAL MONTANA MEDICAL CENTER

Program Components:

Patient Education & Schedule Home Visits:

An enrolled patient receives a series of home visits conducted by a specially trained Community Paramedic (CP). These home visits are designed to:

1. Educate the patient and patient's family on the appropriate ways to manage their healthcare needs. The patient is also assessed for possible enrollment in various healthcare and community-based programs to help meet the patient's clinical, social and/or behavioral health needs. This includes:
    a. Medication compliance
    b. Healthy lifestyle changes
    c. Nutritional Support
    d. Home environment/safety needs
    e. Behavioral health support
2. Educate the patient how to utilize their primary/specialty care network to help manage their medical needs. This includes:
    a. When to call for an appointment
    b. How to call for an appointment
    c. Important information to share with care providers
    d. How to utilize transportation services

During the intake visit, the patient is also asked to assess their own health status using a health survey.

Unscheduled Home Visits:

The patient is provided a 10-digit, non-emergency access number for the CMMC Community Paramedic. In the event they would like a phone consultation or an unscheduled home visit between scheduled visits.

9-1-1 Responses:

Enrolled patients are tracked in Central Montana Dispatch Center's computer aided dispatch (CAD) program. In the event of a 9-1-1 call to the residence, the normal EMS system response is initiated, but the CP is also dispatched to the scene when available. Once on-scene, the CP may be able to intervene and prevent an unnecessary ambulance trip to the emergency department by employing the use of the alternative protocols available to the patient enrolled in this program.

Record Keeping:

Patients enrolled in the program have a continual electronic medical record (EMR) that allows all care providers mobile access to the patient's entire course of assessments and treatments during enrollment, including care notes, vital signs, ECG tracings and treatments initiated. These records can be electronically provided to any caregiver with access to fax or email.

Care Coordination:

CMMC CP will coordinate with all case workers, community service agencies, and other care providers to review the program and enrolled patients to help meet any needs of the enrolled patients and to improve program resource coordination.

Graduation:

After the patient has demonstrated the ability to better manage their healthcare needs, the patient is graduated from the program, provided a graduation certificate, a patient satisfaction survey and the patient is asked to re-assess their own health status using a health survey. This data is tracked to help measure program effectiveness and identify areas of potential improvement.

Referral Process:

Please send referrals to aphelps@cmmccares.com or use attached referral form.

Please include the following information in your referral:

Patient Name:

Date of Birth:

Gender:

Phone:

Address/ Site where Pt will be for visit:

Date Patient should be seen:

Frequency of visits:

Reason for Referral (Diagnosis or History relevant to referral):

Current Medications:

Allergies:

Physician Orders:

(Include: dose, route, rate/volume, frequency, and duration as applicable)

Tests Requested:

*Community Paramedics will assess Vital Signs on arrival for all Patients (GCS, HR, RR, Temp, BP, SpO2)

Blood Glucose, Weight, ECG (will be sent to referring physician office for review)

Labs (Attach requisition) Other _____

Referral Source:

Physician Name and best method to contact.

Phone and Fax number.