Michigan
Community Integrated Paramedicine Protocols
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Initial Date: December 21, 2020 Section 11
Revised Date: 10/28/22

Purpose: To establish minimum and consistent requirements for MDHHS approved CIP Special Study programs throughout Michigan.

I. Definitions and Acronyms
   a. CIP – Community Integrated Paramedicine: The MDHHS umbrella term. encompassing both Community Paramedicine and Mobile Integrated Health
      i. CP – Community Paramedicine: Providers possess broad based MDHHS approved education. CP programs may conduct both scheduled and unscheduled visits as approved by the MCA and may take referrals directly from the 9-1-1 system.
      ii. MIH – Mobile Integrated Health: Providers possess focused MDHHS approved education enabling them to conduct care outlined in a single MDHHS approved CIP protocol. MIH programs conduct scheduled visits.
   b. CP – Community Paramedic: A paramedic who has successfully completed an MDHHS approved community paramedicine education program.
   c. MIH Paramedic – Mobile Integrated Health Paramedic: A paramedic who has fulfilled the education requirement set forth by the MCA to conduct care as outlined in a MDHHS approved CIP protocol.
   d. CPU – CP Unit: A vehicle licensed as and compliant with MDHHS standards as an ALS transporting vehicles, or an ALS non-transporting vehicle. A CP Unit must be utilized to conduct any, and all CIP care with the single exception of a community outreach provider visit **see Community Outreach Provider Visit protocol.**
   e. CIP MD - Community Integrated Paramedicine Medical Director – Physician with oversight for CIP program (s). This may be the MCA Medical Director or an MCA and MDHHS approved designee.
   f. QATF – Quality Assurance Task Force
   g. SDOH - Social Determinants of Health – “conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of life-risks and outcomes” (CDC).

II. CIP Program Requirements
   a. All CIP programs must:
      i. Be approved by MDHHS as a Special Study.
      ii. Be approved by the MCA.
      iii. Possess a CIP Medical Director approved by the MCA and MDHHS.
      iv. Utilize only personnel that have met MDHHS education requirements
      v. Conduct care within the parameters of the MCA’s adopted MDHHS approved protocols
      vi. Comply with MDHHS guidelines.
      vii. Further and without contradiction to MDHHS guidelines, comply with MCA guidelines.
      viii. Further and without contradiction to MDHHS or MCA guidelines, comply with agency guidelines.

b. CIP Special Study programs are allotted an initial 3-year term to provide services.
    i. CIP Special Study programs may be terminated at any time by the privileging MCA or MDHHS for failure to comply with MDHHS or MCA requirements.
    ii. CIP Special Study programs will be reviewed by the QATF 3 years after the initial approval date. Programs will be:
        1. Continued as special studies with continued MDHHS oversight and reviews
        2. Discontinued

III. CIP Protocol Requirements
a. All CIP programs will adopt the following MDHHS approved protocols, or an MCA adapted version approved by MDHHS which achieves the same goals:
    i. CIP Program Policy.
    ii. CIP Medical Director Role & Responsibility.
    iii. CIP Medical Direction.
    iv. CIP Scope of Service/Treatment Capability.
    v. CIP Documentation.
    vi. CIP Program Enrollment
    vii. CIP Patient Service Plan/Care Plan
    viii. CIP Program Discharge
    ix. CIP Fall Risk Reduction Assessment
    x. CIP SDOH Assessment
    xi. CIP Medication Audit
    xii. CIP Patient General Assessment and Care
b. All CIP programs will have MDHHS approved protocols that address the following:
    i. CIP procedures performed.
    ii. CIP medications administered.
    iii. CIP treatments and focused populations served.
c. All CIP programs will have protocols or MCA and MDHHS approved policies and procedures that address:
    i. Personnel requirements.
    ii. Minimum staffing requirements.
    iii. Dispatching requirements.
    iv. Personal vehicle usage.
    v. Vulnerable adult recognition.
    vi. Reporting process for suspected adult or child neglect, abuse, or exploitation.
    vii. Patient encounters outside of work.
    viii. Self-reporting for suspected errors.
    ix. Receipt of gifts.
    x. Conflict of interest language that prohibits providers from entering relationships or signing documentation that results in a recognized

position of authority or advocacy on the patient's behalf regardless of legal recognition

d. Protocols must be reviewed minimally every 3 years
e. In the event an MCA has adopted procedure or treatment protocols which do not apply to all CIP programs within the MCA, it will be up to the MCA develop a Quality Assurance system to ensure programs are only utilizing medications and the corresponding protocols for which they are credentialed.

IV. Reporting Requirements
a. CIP Data Submission
i. All CIP programs will submit MDHHS required data directly to MDHHS on the quarterly basis that a minimum will include:
1. Number of visits conducted (both unique patients and total number of visits)
2. Number of patients that accepted enrollment into the CIP program (if applicable)
3. Average number of patients enrolled at any given time during the quarter (if applicable)
4. Number of patients that received at least one CIP Fall Risk Reduction Assessment
5. Number of patients receiving at least one CIP Fall Risk Reduction Assessment in which a correction or referral needed to be made
6. Number of patients that received at least one CIP Medication Audit
7. Number of patients that received at least one CIP Medication Audit in which a correction or referral needed to be made
8. Number of patients that received at least one CIP SDOH Assessment
9. Number of patients that received at least one CIP SDOH Assessment in which a correction or referral needed to be made
10. Number of CIP calls that ended in a disposition of patient being transported to or sent to the emergency room by any mode of transportation.
11. Additional MDHHS reporting requirements will be based on the CIP programs specific lines of service.

ii. All CIP programs will submit MCA required data to the MCA per the schedule established by the MCA.
iii. MCA's will submit all collected data to MDHHS on the quarterly basis.

b. The following events must be reported to the CIP-MD and the MCA within 24 hours of the occurrence regardless of conclusion of an investigation.
i. Death of a patient suspected to be related to the actions or inactions of a CIP provider or program.
ii. Illness or injury suspected to be related to the action or inactions of a CIP provider or program.

iii. Accusations of misconduct, practicing outside of the established protocol dictated scope of CIP practice or abuse of power.

CIP MEDICAL DIRECTOR ROLE AND RESPONSIBILITIES

Initial Date: July 23, 2020
Revised Date: Section 11-02

Purpose: To outline the roles and responsibilities of the CIP Medical Director.

I. A CIP Medical Director will be the MCA Medical Director and additionally may be
   a. ☐ A physician appointed by the MCA Medical Director and approved by both the Medical Control Board and MDHHS (optional)

II. CIP Medical Director responsibilities:
   a. Medical operations of specified CIP program(s)
   b. Development of CIP protocols
   c. CIP personnel criteria and selection process
   d. Credentialing (MCA privileges) of CIP personnel
   e. Establishing a quality assurance process and schedule which must be approved by the following:
      i. MCA
      ii. MDHHS
   f. Remediation of CIP personnel, as necessary.
      i. MDHHS and the MCA Medical Director must be advised of any CIP requiring remediation within 30 days of the incident
   g. Development and oversight of CIP continuing education
   h. Data submission to the MCA
   i. Data submission to MDHHS

III. The CIP MD privileges are at the discretion of the MCA Medical Director and the MCA Board. CIP Programs are not allowed to function in an MCA without expressed approval from the MCA and MDHHS.

Initial Date: July 23, 2020

Revised Date: Section 11-03

Medical Direction

I. CIP providers will be continuously monitoring for signs of life-threatening or urgent but not life-threatening medical needs. If a CIP provider encounters:
   a. Life threatening medical needs
      i. Initiate local 9-1-1 response
   b. Urgent but not life-threatening medical needs beyond what is written in the orders for the visit.
      i. May initiate local 9-1-1 response prior to establishing online medical direction
      ii. Hierarchy for establishing online medical direction.
         a. First contact – MCA approved referring physician
         b. If unsuccessful, second contact will be the MCA approved referring physician's on-call service provider
         c. If unsuccessful, third contact will be the CIP Medical Director (if applicable)
         d. If unsuccessful, fourth contact will be the MCA's online medical control
         e. If unsuccessful, initiate local 9-1-1 response

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II. Non-Urgent Medical Needs
   a. Medical Direction for CIP visits that lack immediate life-threatening or urgent medical needs may be provided by:
      i. Online MCA Medical Direction
      ii. MCA approved referring physician
      iii. MCA approved Primary Care Physician (PCP)

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Program Protocol
SCOPE OF SERVICE/TREATMENT CAPABILITIES

Initial Date: July 23, 2020
Revised Date: Section 11-04

Purpose: To communicate the program types, patient protocols, and procedures allowed within the MCA. Marked categories will have corresponding protocols. MCA's will track and report to MDHHS the protocols applicable to each CIP Program.

1. CIP Program Types will include (choose from the following):
   - II. Scheduled appointment and physician's order using **Community Outreach Provider Visit protocol** (no minimum vehicle requirement)
     - a. ☒ Community Paramedic (optional)
     - b. ☐ Mobile Integrated Health Paramedic (optional)
   - III. Scheduled appointment for enrolled patient
     - a. Community Paramedic
     - b. ☐ Mobile Integrated Health Paramedic (optional)
   - IV. Episodic (unscheduled) care for an enrolled patient.
     - a. Community Paramedic
     - b. ☐ Mobile Integrated health Paramedic (optional)
   - V. Low acuity 9-1-1 calls
     - a. Community Paramedic
2. Patient protocols
   - a. Will include:
     - i. CIP Patient General Assessment and Care
   - b. May include:
     - i. ☒ CIP Diabetic Care
     - ii. ☒ CIP Asthma Care
     - iii. ☒ CIP Chronic Obstructive Pulmonary Disease Care
     - iv. ☒ CIP Congestive Heart Failure
     - v. ☒ CIP Chronic Hypertension Care
     - vi. ☒ CIP Post MI or Cardiac Intervention Care
     - vii. ☒ CIP Post Orthopedic Surgery Care
     - viii. ☒ CIP Post Stroke Care
     - ix. ☐ CIP Prenatal Care
     - x. ☐ CIP Mom/Baby Postpartum Care

xi. ☒ CIP Sleep Apnea Care
xii. ☒ CIP Wound Care
xiii. ☒ CIP Substance Use Disorder Care
xiv. ☒ CIP Skin Rash Complaints
xv. ☒ CIP Urinary Complaints
xvi. ☒ CIP Gastrointestinal Complaints
xvii. ☒ CIP Lower Respiratory Infection Complaints
xviii. ☒ CIP Sore Throat and Upper Respiratory Complaints
xix. ☒ CIP Nontraumatic Nosebleed Complaints

3. Procedure protocols
   a. Will include:
      i. CIP Fall Risk Reduction Assessment
      ii. CIP SDOH Assessment
      iii. CIP Medication Audit
   b. May include:
      i. ☒ CIP Community Outreach Provider Visit
      ii. ☒ CIP Feeding Tubes
      iii. ☒ CIP Urinary Catheters
      iv. ☒ CIP Ostomies
      v. ☐ CIP Nasal Packing
      vi. ☒ CIP Specimen Collection
      vii. ☒ CIP Point of Care Testing for Blood Analysis
      viii. ☒ CIP Suture Removal
      ix. ☐ CIP Otoscope
      x. ☒ CIP Intravenous Access
      xi. ☒ CIP Vaccinations

xii. ☐ CIP Naloxone Leave Behind

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Program Protocol
DOCUMENTATION

Initial Date: July 23, 2020
Revised Date: Section 11-05

Purpose: To provide guidance for documentation of CIP services

I. Patient contacts will be documented in an EPCR system including:
   a. Face to face contact with or without treatments rendered
   b. Telephone/telehealth contact

II. Communications with all persons regarding a patient will be documented in an EPCR system. Examples include but are not limited to:
   a. Licensed health care providers
      i. Communications with licensed health care providers that influence the route of care (receiving an order from or reporting an issue to) should include name, agency, date, time and issue relayed to provider.
   b. Family members
   c. Social service organizations
   d. Meals on wheels
   e. Volunteer organizations
   f. Community organizations

III. EPCRs will be available to the referring physician within 24 hours of the completion of the visit. Transmission of electronic records will be determined by MCA.

IV. Things that cannot be documented directly into the EPCR will be attached to the EPCR. This includes but is not limited to forms and checklist that are not housed within the EPCR such as:
   a. Consent forms
   b. Physician created care plans
   c. Checklists
   d. Medication lists
   e. Physician's orders

V. Procedure protocol documentation will include:
   a. Evaluation findings
   b. Interventions
   c. Response to interventions (Results may be improved, unchanged, or worsened)

Initial Date: July 23, 2020
Revised Date: Section 11-06

Purpose: To provide guidelines for patient enrollment into Community Integrated Paramedicine Programs.

I. Enrollment to a CIP program will be necessary in the following situations:
   a. A physician's referral
   b. Anticipation of more than 1 visit (includes but not limited to phone, telehealth/telemedicine, in person).

II. Enrollment will include:
   a. Physician's referral (physician name should be documented in EPCR)
   b. Documented patient consent
   c. Documented intake assessment including but not limited to:
      i. Physical assessment with notation to overall physical and mental statuses and limitations both physical and cognitive
      ii. Fall risk reduction assessment **see Fall Risk Reduction Assessment protocol**
      iii. Social determinants of health assessment **see SDOH Assessment protocol**
      iv. Medication audit **see Medication Audit protocol** (optional)
   d. Development of a service plan/care plan

III. Patient enrollment including the intake assessment must be documented within the EPCR or attached to the EPCR

IV. Whenever possible CIP services should work in conjunction with already established services available within the community.

Purpose: To outline the minimum elements that must be included in a service plan/care plan for patient's enrolled in CIP programs.

I. The CIP patient service plan/care plan will include (if applicable):
   a. Short and long-term health care needs and goals including timeframes for meeting the goals (including end of life care).
   b. A description of the out-of-hospital services needed to address and satisfy the patient's needs and goals.
   c. Frequency of visits and projected number of visits.
   d. A goal for the patient's discharge
   e. Medications administered
   f. Medication audits performed and findings
   g. Prescriptions provided
   h. Decline in physical or mental health
   i. Decline in mobility or capacity for self-care
   j. Change in environment or person's residing within the environment
   k. Admission to a hospital
   l. Medications or treatment rendered
   m. Unscheduled or episodic care provided by the CIP program
   n. Clinic or physician follow up schedule and logistics for follow up compliance if indicated.

II. The CIP patient service plan/care plan will be updated upon each visit.

III. The CIP service plans/care plan must be documented within the EPCR or attached to the EPCR.

Initial Date: July 23, 2020
Revised Date:

Section 11-08

Purpose: To provide guidelines for patient discharge or disenrollment from a Community Integrated Paramedicine Program.

Aliases: Dis-enrollment, graduation

I. Planned Discharges
   a. Goals met and physician discharges
   b. Expirations of physician's order
   c. Referral to higher level of care

II. Unplanned Discharges
   a. Cancelation/missing more than 3 visits without notice or valid cause
   b. Non-adherence to goals
   c. Relocation
   d. Patient/family request
   e. Unsafe situation for the CIP provider
   f. Death

III. Discharge documentation will include:
   a. How and when the patient was informed
   b. How and when the ordering physician was informed
   c. Health status upon last visit
   d. Concerns of discontinued care
   e. Persons informed of concerns

IV. Discharges must be documented within the EPCR or attached to the EPCR.

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Procedure Protocol
FALL RISK REDUCTION ASSESSMENT

Initial Date: August 28, 2020
Revised Date: Section 11-26

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide guidelines for the minimum elements of a fall risk reduction assessment and when it should be performed with the intent of reducing preventable falls.

Aliases: Home safety assessment, Fall risk check

I. Indications
   a. CIP encounter
II. Contraindication
   a. None
III. Equipment
   a. MCA approved fall risk reduction assessment checklist which will include
      i. Evaluation of environment
      ii. Evaluation of patient's ability in current state to maneuver in environment
   b. An MCA may elect to use an MCA approved abbreviated version of the fall risk reduction checklist for the following situations:
      i. Subsequent visits of an enrolled patient with no notable change in environment or patient status.
      ii. Non-scheduled visits that do not allow time for a fall risk reduction assessment due to the disposition of the patient
IV. Procedure
   a. Perform fall risk reduction assessment following MCA approved checklist.
   b. Findings that present threats to the patient's immediate health and well-being must be reported to the referring prior to the conclusion of the visit.
V. Documentation **see CIP Documentation protocol**
   a. Additionally
      i. Completion of checklist
      ii. Findings
      iii. Corrections or plan for corrections
      iv. Inability to complete corrections and reason

MCA Name: Marquette Alger MCA
MCA Board Approval Date: 11/12/2024
MCA Implementation Date: 1/31/2025
Protocol Source/References:

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Procedure Protocol
SOCIAL DETERMINANTS OF HEALTH ASSESSMENT

Initial Date: August 28, 2020
Revised Date: Section 11-27

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide guidelines for the minimum elements of a Social Determinants of Health (SDOH) assessment and when it should be performed with the intent of reducing barriers to optimal health.

Aliases: Health care barriers

I. Indications
   a. Intake/enrollment assessments
   b. Referring physician request
   c. As deemed necessary by CIP provider
II. Contraindications
   a. None
III. Equipment
   a. MCA approved SDOH Assessment Form which will include:
      i. Housing, transportation access, safety within their environment, food security, social exclusion, social support, healthcare access and addiction.
IV. Procedure
   a. Perform SDOH assessment following MCA approved checklist.
   b. Assess both the patient and their environment
   c. Findings that present threats to the patient's immediate health and well-being must be reported to the referring physician prior to conclusion of the visit.
V. Documentation **see CIP Documentation protocol**
   a. Additionally
      i. Completion of check list
      ii. Findings
      iii. Corrections, referrals or plans for either
      iv. Inability to complete corrections or referrals and reason

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Procedure Protocol
MEDICATION AUDIT

Initial Date: August 28, 2020
Revised Date: Section 11-28

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide guidelines for the minimum elements of a medication audit and when it should be performed.

I. Indications
   a. CIP Encounter
II. Contraindications
   a. None
III. Equipment
   a. MCA approved medication audit checklist which will include:
      i. Medication expiration dates
      ii. Dispensing method of medications that works for the patient
      iii. Barriers to obtaining medications
      iv. Questions or concerns patient has regarding medications which will be forwarded to PCP or referring physician.
IV. Procedures
   a. Perform medication audit according to referring physician directions or MCA approved medication audit checklist when physician orders are not present.
   b. Findings that present threats to the patient's immediate health and well-being must be reported to the referring physician prior to the conclusion of the visit.
V. Documentation **see CIP Documentation protocol**
   a. Additionally
      i. Completion of medication audit
      ii. Findings
      iii. Name of provider notified of the discrepancy along with date and time of notification
      iv. Course of action determined appropriate by online medical control if applicable

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Procedure Protocol
FEEDING TUBES

Initial Date: November 13, 2020
Revised Date: Section 11-29

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: Provide guidelines for CIP paramedics to maintain a percutaneous tract into the stomach or a nasogastric tube through evaluation of efficacy and either rectifying or making a referral for ineffective tracts.

Aliases: Feeding Tubes, NG tubs, PEG tubes

I. Indications
   a. Complaints including blockage, damage or need for replacement
II. Contraindication
   a. Signs of infection or active bleeding
III. Equipment
   a. 10 ml syringe
   b. Warm water or carbonated beverage such as diet cola
   c. Approved de-clogging device designed for the tube.
IV. Procedure
   a. Identify the type of feeding tube.
   b. Examine for patency, functionality, and placement.
   c. If there is evidence of blockage, using sterile technique flush the tube using a 10 ml syringe and water or carbonated beverage.
      i. If unable to flush use carbonated beverage and let it sit for 5-10 minutes and reattempt flushing.
   d. If unable to establish good flow and the tube is in place, consider making arrangement for replacement.
   e. ☐ Nasogastric tube removal (optional)
      i. Obtain medical direction prior to procedure
      ii. Position patient a minimal of a 30-degree incline from supine to prevent aspiration
      iii. Discontinue gastric suction
      iv. Flush the tube with a small bolus of air to clear any remaining gastric contents
      v. Remove securement device
      vi. Fold over or clamp the proximal end of the tube to prevent backflow of gastric contents
      vii. Direct patient to hold the breath to close the epiglottic and withdraw the tube gently and steadily.
      viii. When the distal end of the tube reaches the nasopharynx, it can be pulled quickly
      ix. Inspect the tube to ensure it is intact
   f. ☐ Replacement of damaged percutaneous tube in a well-established tract (optional)

i. Indications
    a. Inadvertent removal of a tube
ii. Contraindications
    1. Initial gastrostomy placed less than 2 months ago
    2. Tube has been out of place for more than 24 hours
iii. Procedure
    1. Consider analgesics
    2. Utilize sterile technique
    3. Insert largest appropriate replacement tube (urinary catheter)

g. Concerns that present threats to the patient's immediate health and well-being must be reported to the referring physician prior to the conclusion of the visit.

V. Documentation **see CIP Documentation protocol**

a. Additionally (if applicable)
    i. Results of attempts to flush tubes
    ii. Removal of NG tubes, tube intact and patient reaction
    iii. Replacement of percutaneous tract tube, confirmation of placement and measurements

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: Provide guidelines for CIP paramedics to evaluate efficacy, rectify issues or make appropriate referrals for ineffective urinary catheters. Allow placement of urinary catheters for patients with known recurring urinary retention.

Aliases: Foley, cath, suprapubic catheter, indwelling catheter, urinary catheter, sterile technique = aseptic technique.

I. Indications for urinary catheter care
   a. blockage or damage of the catheter
   b. physician ordered replacement
   c. need for removal
   d. need for removal and reinsertion
   e. catheterization for relief of urinary retention
   f. Consult with referring physician prior to initial placement of a urethral catheter unless it is explicitly written in the physician's orders.

II. Contraindications
   a. Recent external trauma to pelvis

III. Equipment
   a. Appropriate size urethral catheter (5Fr-26Fr)
   b. Collection bag
   c. Syringe (10ml, 20ml or 30ml)
   d. Lubricant
   e. Lidocaine Jelly 2%
   f. Sterile water
   g. Sterile field kit

IV. Procedures
   a. Flushing of an indwelling catheter
      i. Identify the type of catheter.
      ii. Examine the catheter for patency, functionality, and placement.
      iii. If there is evidence of blockage, using sterile technique flush the tube using a 10-30 ml syringe using sterile water at room temperature. .
      iv. If unable to establish good flow, the catheter is non-functional, damaged or has become displaced consider removal and replacement.
   b. Removal of urethral or suprapubic catheter
      i. Empty bag of urine
      ii. Remove all fluid from balloon
      iii. Gently remove
      iv. Note length of the tube section that was inserted
   c. Placement or replacement of urethral catheter

i. Obtain medical direction prior to initial placement of an indwelling urethral catheter
ii. Prepare sterile field, utilize sterile technique
iii. Check balloon for patency
iv. Generously coat the distal portion (2-5 cm) of the catheter with lubricant and/or 2% Lidocaine Jelly 5 to 30 ml for males and 3-5 ml for females.
v. Females, separate labia using non-dominant hand. For males, hold the penis with the non-dominant hand.
vi. Maintain hand position until preparing to inflate balloon.
vii. Using dominant hand to handle forceps, cleanse peri-urethral mucosa with cleansing solution. Cleanse anterior to posterior, inner to outer, one swipe per swab, discard swab away from sterile field.
viii. Pick up catheter with gloved (and still sterile) dominant hand. Hold end of catheter loosely coiled in palm of dominant hand.
ix. In the male, lift the penis to a position perpendicular to patient's body and apply light upward traction (with non-dominant hand)
x. Identify the urinary meatus and gently insert until 1 to 2 inches beyond where urine is noted
xi. Inflate balloon, using correct amount of sterile liquid (usually 10 cc but check actual balloon size)
xii. Gently pull catheter until inflation balloon is snug against bladder neck
xiii. Connect catheter to drainage system
xiv. Secure catheter to abdomen or thigh, without tension on tubing
xv. Place drainage bag below level of bladder
xvi. Evaluate catheter function and amount, color, odor, and quality of urine
xvii. Remove gloves, dispose of equipment appropriately, wash hands
xviii. Document size of catheter inserted, amount of water in balloon, patient's response to procedure, and assessment of urine

d. Replacement of existing suprapubic catheter
i. Prepare sterile field, utilize sterile technique
ii. Check balloon for patency
iii. Clean and lubricate the insertion site area
iv. Insert the catheter into the suprapubic site the same distance as the catheter removed.
v. Inflate balloon, using correct amount of sterile liquid (usually 10 cc but check actual balloon size)
vi. Gently pull catheter until inflation balloon is snug against bladder neck
vii. Connect catheter to drainage system
viii. Secure catheter to abdomen or thigh, without tension on tubing
ix. Place drainage bag below level of bladder
x. Evaluate catheter function and amount, color, odor, and quality of urine
xi. Remove gloves, dispose of equipment appropriately, wash hands
xii. Document size of catheter inserted, amount of water in balloon, patient's response to procedure, and assessment of urine

V. Concerns that present threats to the patient's immediate health and well-being must be reported to the referring physician at the conclusion of the visit, all other concerns within 24 hours.

VI. Documentation **see CIP Documentation protocol**
   a. Additionally:
   i. Color, odor, and quantity of urine when applicable

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Procedure Protocol
OSTOMY BAG REPLACEMENT

Initial Date: December 14, 2020
Revised Date: Section 11-31

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: Provide guidelines for CIP paramedics to change an ostomy bag and/or evaluate efficacy and make a referral for ineffective ostomies.

Aliases: Colostomy, ileostomy.

I. Indications
   a. Need for bag replacement or evaluation for complaints including blockage, damage, or signs of infection.

II. Equipment
   a. One or two-piece ostomy appliance

III. Procedure for bag change
   a. Examine the ostomy site for herniation, bleeding, or signs of infection.
      i. If signs of herniation, bleeding or infection are present contact referring physician for orders.
   b. Identify ostomy appliance as either a one piece or a two-piece appliance.
   c. Measure the ostomy site if it is less than 6 weeks old.
   d. Remove per manufacturer's directions.
   e. Remove excess stool from skin
   f. Prepare skin/site for replacement of flange/wafer if applicable.
   g. Place following manufacturer's directions
   h. Concerns that present threats to the patient's immediate health and well-being must be reported to the referring physician at the conclusion of the visit, all other concerns within 24 hours.

IV. Documentation **see CIP Documentation protocol**

NASAL PACKING PLACEMENT AND REMOVAL

Initial Date: November 13, 2020
Revised Date: Section 11-32

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: Provide guidelines for CIP paramedics to place and/or remove anterior nasal packing as approved by the MCA.

Aliases: Rhino rockets, nasal tampons

I. ☐ Anterior Nasal Packing Placement (optional)
- a. Indications
  - i. Nasal packing for nosebleeds that have not been controlled by lesser measures **see CIP Non-Traumatic Nosebleed protocol**
- b. Contraindications
  - i. Nosebleeds caused by trauma
- c. Equipment
  - i. MCA approved manufactured nasal packing that includes manufacturer recommendations for placement and usage
- d. Procedure
  - i. Obtain medical direction prior to procedure
  - ii. Follow manufacturer's directions for placement
  - iii. Remain with patient for 30 minutes to assure bleeding has stopped
    1. If bleeding has not stopped activate 9-1-1 for transport to an emergency department
  - iv. Arrange for follow-up with PCP within 24-48 hours.
    1. If follow-up with PCP cannot be made withing 24-48 hours schedule CIP follow-up within 24 for nasal packing removal.
- e. Documentation **see CIP Documentation protocol**

II. ☐ Anterior Nasal Packing Removal (optional)
- a. Indications
  - i. Nasal packing has been in place for 24-48 hours
- b. Contraindications
  - i. Active bleeding
- c. Equipment
  - i. Syringe
- d. Procedure
  - i. Obtain medical direction prior to procedure
  - ii. Evaluate for presence of balloon
  - iii. Deflate balloon completely with appropriate size syringe
  - iv. Gently pull the strings attached to the packing until packing is completely removed
  - v. Observe patient for 5 minutes to ensure bleeding does not reoccur.

1. If bleeding reoccurs **see CIP Non-Traumatic Nosebleed protocol**

e. Documentation **see CIP Documentation protocol**

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Procedure Protocol
SPECIMEN COLLECTION

Initial Date: October 23, 2020
Revised Date: Section 11-33

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: Provide guidelines for CIP paramedics to obtain and transport specimen at the request of a health care provider as approved by the MCA

Aliases: labs, strep test, swab test

I. Indications
   a. Order from a clinician requesting specimen collection to be obtained and transported to the appropriate testing facility when a patient has a barrier to submitting specimens in a timely manner.
   b. Specimen collection for the purpose of point of care testing.

II. Procedure
   a. For all procedures accompanied by a physician's order.
      i. Review order for special instructions prior to collecting the specimen
      ii. Label with the patient's name, date of birth, and additional information required for the specific specimen (source, date, time) or required by the MCA or specimen testing facility.
      iii. Complete appropriate lab paperwork.
      iv. Transport sample in a biohazard bag or follow clinician's order for shipping.
   b. ☐ Lab Draw (optional)
      i. Considerations: Patients who are on blood thinners may require prolonged direct pressure after blood draw. Equipment
         1. Appropriate needle
         2. Rainbow tubes
      ii. Procedure
         1. Select an appropriate site and using universal precautions cannulate the vein.
         2. Blood tubes should be collected in the order of red, green, purple, pink and blue.
   c. ☐ Urine Specimen (optional)
      i. Equipment
         1. Urine specimen cup
         2. wipes
      ii. Procedure
         1. Obtain sample through method ordered (clean catch, foley bag, etc.)

d. ☐ Nasal Swab
   i. Equipment – appropriate swabs for specific test
   ii. Procedure
      1. Place patient in seated position
      2. Tilt patient's head back slightly to visualize nasal passages
      3. Gently insert swab along nasal septum, just above the floor of the nasal passage, to the nasopharynx
         a. Stop when resistance is met & do not force the swab further
         b. If resistance is detected, pull back slightly and try reinserting at a different angle, closer to the floor of the nasal canal
         c. The swab should reach a depth equal to the distance from the nostrils to the outer opening of the ear
      4. Rotate swab several times, remaining in the passage for 10 seconds
      5. Gently removed swab while rotating
      6. Place swab into collection tube according to directions and prior to breaking the stick
      7. Secure lid on the tube

e. ■ Throat Swab
   i. Equipment – appropriate swabs for specific test
   ii. Procedure
      1. Place patient in seated position
      2. Tilt patient's head back, instruct them to open their mouth and stick out their tongue
      3. Use a wooden tongue depressor to hold the tongue in place
      4. Visualize the posterior nasopharynx and tonsillar arches
      5. Without touching the side of the mouth, insert the swab reaching the posterior nasopharynx and tonsillar arches wiping the swab on the area
      6. Place swab into collection tube according to directions and prior to breaking the stick
      7. Secure the lid on the tube

III. Documentation **see CIP Documentation protocol**
   a. Additionally: testing procedure used and results if applicable

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Procedure Protocol
POINT OF CARE TESTING FOR BLOOD ANALYSIS

Initial Date: October 23, 2020
Revised Date: Section 11-34

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: Provide guidelines for CIP paramedics to perform advanced point of care testing at patient's side with a CLIA waived device that performs blood analysis. This protocol was designed around the use of the Abbot i-STAT system and Piccolo Xpress system. Always follow manufacturer instructions.

Aliases: Handheld blood analyzer, portable clinical analyzer, i-STAT, Piccolo

I. Indications
   a. Physician's order
   b. CIP Patients who require point of care testing to guide treatment.
II. Contraindications
   a. Not CLIA waived
III. Equipment
   a. CLIA waived point of care testing device with appropriate CLIA waived cartridges for testing.
   b. Appropriate equipment for specific device.
IV. Procedure
   a. Obtain appropriate blood sample.
   b. Follow device's instructions for use.
V. Documentation **see CIP Documentation protocol**
   a. Additionally: cartridges utilized and test results

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Procedure
SUTURE REMOVAL

Initial Date November 13, 2020
Revised Date: Section 11-35

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide guidelines for CIP paramedics to safely remove sutures and/or staples as approved by the MCA.

Aliases: Stitches, staples

I. Indications
   a. Request from a clinician to remove a known type of suture
II. Contraindications
   a. Signs of wound complications or infection
III. Equipment
   a. Forceps
   b. Suture scissors
   c. Staple remover
   d. Sterile gauze
   e. Sterile 0.9% sodium chloride solution
   f. Sterile wound strips
IV. Procedure
   a. Plain suture removal (optional)
      i. Gently grasp the knot or the tail with forceps and raise it slightly
      ii. Place the curved tip of the suture scissors directly under the knot or on the side, close to the skin
      iii. Gently cut the suture and pull it out with the forceps
      iv. Make sure all suture material is removed and placed on clean gauze
      v. Remove alternate sutures
      vi. Assess the wound for dehiscence (edges of the wound do not meet)
         1. Absence of dehiscence
            a. Remove remaining sutures
            b. Apply sterile wound strips to prevent dehiscence
         2. Presence of dehiscence
            a. Do not continue to remove sutures
            b. Cover wound with sterile gauze saturated with sterile 0.9% sodium chloride solution
            c. Contact physician **see CIP Medical Direction protocol**
   b. Staple removal (optional)
      i. Place the lower jaw of the remover under a staple
      ii. Squeeze the handles completely to close the device bending the staple in the middle and pulling the edges of the staple out of the skin
      iii. Gently move the staple away from the incision site when both ends are visible
      iv. Hold the staple remover over a sharps container, relax pressure on the handles, let the staple drop into the sharps container

v. Remove alternate staples
vi. Assess the wound for dehiscence (edges of the wound do not meet)
    1. Absence of dehiscence
        a. Remove remaining staples
        b. Apply sterile wound strips to prevent dehiscence
    2. Presence of dehiscence
        a. Do not continue to remove staples
        b. Cover wound with sterile gauze saturated with sterile 0.9% sodium chloride solution
        c. Contact physician **see CIP Medical Direction protocol**

V. Documentation **see CIP Documentation protocol**
    a. Additionally:
        i. Date and time of removal
        ii. Number of sutures or staples removed
        iii. Dressings or adhesive wound strips applies
        iv. Appearance of the incision

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Procedure Protocol
OTOSCOPE

Initial Date: November 13, 2020
Revised Date: Section 11-36

Purpose: Provide guidelines for CIP paramedics to utilize an otoscope or disposable speculum for patient evaluation.

Aliases: speculum

I. Indications
   a. Need for visualization of the eardrum
II. Contraindications
   a. None
III. Equipment
   a. Otoscope
   b. Otoscope with disposable specula (eartip)
IV. Procedure
   a. Adult positioning
      i. Use otoscope with largest ear speculum that the ear canal will accommodate
      ii. Position patient's head and neck upright
      iii. Grasp auricle firmly and gently, pull upwards, backward and slightly away from the head
      iv. Hold otoscope handle between thumb and fingers and brace hand against patient's face
      v. Insert speculum into ear canal, directing it somewhat down and forward and through hairs
   b. Child positioning
      i. Child may sit up or lie down
      ii. Hold otoscope with handle pointing down toward child's feet while pulling up on auricle
      iii. Hold the head and up on auricle with one hand while holding otoscope with the other hand
      iv. Insert speculum into ear canal, directing it somewhat down and forward and through hairs
   c. Inspection for both adult and child
      i. Inspect ear canal noting discharge, foreign bodies, redness and/or swelling
      ii. Inspect eardrum noting color and contour and perforations
V. Documentation **see CIP Documentation protocol**
   a. Additionally:
      i. Eardrum color, translucency, and presence or absence of swelling or perforation.
      ii. Ear canal discharge, foreign bodies, redness and/or swelling

PERIPHERALLY INSERTED CENTRAL CATHETER (PICC) ACCESS

Initial Date: October 23, 2020
Revised Date: Section 11-37

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: Provide guidelines for the use of PICC lines.

Aliases: PICC

I. Peripherally Inserted Central Catheters (PICC
   a. Description: PICC lines are long catheters inserted through a vein in the arm, leg or neck with the terminal end positioned in the superior vena cava, inferior vena cava, or the proximal right atrium. PICC lines are used for long duration access generally up to 6 months.
   b. CIP Uses: Accessing for medications, antibiotics, parenteral nutrition, and blood draws.
   c. Indications
      i. Accessing for blood draws or administration of fluids and/or medications
      ii. Maintenance including flushing, dressing change and evaluation of insertion site
   d. Contraindications
      i. Has not been used and confirmed
      ii. Suspicion it is not patent
      iii. Signs of infection at site
   e. Equipment
      i. Saline Flush (x2)
      ii. 10 cc syringe (x2)
   f. Procedure
      i. Appropriate PPE and use sterile technique
      ii. Evaluate the site for redness, pain, exudate, and the arm for swelling, pain and stiffness
      iii. Flush the PICC line with 10ml of NS
      iv. Administer medications and/or fluids a prescribed or draw blood for labs
      v. Flush the PICC line with 10ml NS

II. Documentation **see CIP Documentation protocol**

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Procedure Protocol
VACCINATIONS

Initial Date: October 23, 2020
Revised Date: Section 11-38

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide guidelines for the administration of vaccinations as approved by the MCA.

Aliases: Immunizations

I. Indications
   a. Order from a clinician requesting the administration of a vaccination
   b. Participation in mass immunization settings

II. Vaccinations eligible for administration by CIP paramedics as approved by the MCA include:
   a. ☐ Chickenpox (Varicella)
   b. ☐ Diphtheria
   c. ☐ Flu (Influenza)
   d. ☐ Hepatitis A
   e. ☐ Hepatitis B
   f. ☐ Hib (Haemophilus influenzae type b)
   g. ☐ HPV (Human Papillomavirus)
   h. ☐ Measles
   i. ☐ Meningococcal
   j. ☐ Mumps
   k. ☐ Pneumococcal
   l. ☐ Polio (Poliomyelitis)
   m. ☐ Rotavirus
   n. ☐ Rubella (German Measles)
   o. ☐ Shingles (Herpes Zoster)
   p. ☐ Tetanus (Lockjaw)
   q. ☐ Whooping Cough (Pertussis)
   r. ☐ COVID 19 when available

III. Contraindications
   a. Allergies noted in pre immunization screening

IV. Equipment
   a. Vaccine
   b. Appropriate delivery device

V. Procedure
   a. Timing and dosing of immunizations will be determined by the PCP and/or public health department
   b. Pre immunizations screening must be done prior to administration of the vaccination

c. Vaccinations may be administered via IM, SQ or intranasal route as appropriate for the specific vaccination
d. Verify Michigan Care Improvement Registry (MCIR) documentation

VI. Documentation **see CIP Documentation protocol**

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Procedure Protocol
NALOXONE LEAVE BEHIND

Initial Date: November 19, 2020
Revised Date: Section 11-39

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: Provide guidelines for CIP paramedics to leave a Naloxone kit with patients who are being evaluated and cared for due to a narcotic substance use disorder.

Aliases: Leave behind, Narcan kit

I. Indications
   a. Patient is enrolled in a CIP program
II. Contraindications
   a. Under the age of 18
III. Equipment
   a. Prepackaged naloxone kit **see CIP Naloxone Medication Kit Contents and Distribution protocol**
IV. Procedure
   a. Provide naloxone kit to patient
   b. Educate patient and support persons on use of naloxone kit
      i. Demonstrate administration with dummy intranasal device and water
         1. Allow patient to express water from intranasal device
      ii. Discuss the importance of respiratory support
      iii. Discuss the importance of initiating a 9-1-1 response
      iv. Discuss the risks of an opioid medication half-life potentially being longer than the duration of naloxone
      v. Discuss the risks of a single does of naloxone being insufficient for full reversal
V. Documentation **see CIP Documentation protocol**

MCA Name: Marquette Alger MCA
MCA Board Approval Date: 11/12/2024
MCA Implementation Date: 1/31/2025
Protocol Source/References:

Naloxone Medication Kit Contents and Distribution Procedure

I. Medications and supplies for naloxone kits will be supplied by member facilities within the MCA.
II. Assembly, labeling, and access to kits will be done according to the **Pharmacy, Drug Box and IV Supply Exchange Procedure.**
III. Overdose Medication Kit Contents List

Medication / Item	Concentration	Packaging	Quantity
Naloxone (Narcan)	4mg / spray	Nasal Spray	1
MDHHS Safety Advice for Patient and Family Members Card			1
Resuscitation Face shield*			1* *(MCA Optional)
Replacement Form			1
Local Treatment Resources Form			1

IV. Procedure

A. Each participating EMS Agency will stock each of its licensed vehicles with 2 Naloxone Medication Kits. After deployment, the naloxone medication kit will be replaced within 24 hours at the assigned stocking hospital pharmacy.
B. Kits will be stored on the EMS vehicle in a secure way, not accessible to the public.
C. Deployment of a Naloxone Medication Kit will be documented the patient care record and uploaded to the Michigan EMS Information System.
D. The replacement/use form will be completed and returned to the designated hospital pharmacy for dispensing of a replacement Naloxone Kit.

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Treatment Protocol
CIP PATIENT GENERAL ASSESSMENT AND CARE
Initial Date: October 23, 2020
Revised Date: Section 11-50

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide guidelines for evaluation and care of patients under a CIP program.

I. Prior to initiation of patient contact review the following when available:
   a. Patient complaint/illness/reason for visit
   b. Available previous pertinent patient care records
   c. Physician's orders
   d. Protocols pertinent to patient condition, patient complaint or physician's orders as these will contain additional requirements and suggestions for vital signs, history, diagnostics, and patient counseling/education.

II. Evaluate for presence of potentially life-threatening medical needs upon arrival and monitor continuously throughout care.
   a. Potentially life-threatening medical needs exist, initiate 9-1-1 response **see CIP Medical Direction protocol**
      i. Suspend CIP call and utilized local MCA protocols as necessary

III. Verify patient complaints and history with patient and other available sources.
   a. Sources may include but are not limited to referring agency, referring physician, referring EMS unit or family

IV. Perform a physical exam pertinent to patient's complaint or condition.

V. Perform diagnostic studies as indicated by patient complaint/illness/reason for visit.
   a. Diagnostics: blood glucose level, ECG, ETCO2, I-STAT, other studies as available.

VI. Determine patient disposition:
   a. Transport to the emergency department
      a. Conditions in which transport to the emergency department should be considered:
         1. Altered level of consciousness
         2. Potential sepsis
         3. Vital sign compromise or instability
      b. Procedure
         1. Activate 9-1-1 response
         2. Remain with patient until transporting unit arrives
         3. Notify physician of transport **see CIP Medical Direction protocol**

4. Document **see CIP Documentation protocol**

b. On-scene treatment indicated:
   a. Initiate care: **see applicable Care (treatment) and/or Complaint (treatment) protocol(s)** seeking medical direction as indicated per protocol.
      1. All on-scene medical treatment must have standing orders from the referring physician or direct online medical control.
   b. Evaluate patient response to treatment and determine patient disposition (go back to VI).
c. On-scene treatment not indicated or completed with desired results:
   a. Fall Risk Reduction Assessment **see CIP Fall Risk Reduction Assessment protocol**
   b. Social Determinants of Health Assessment **see CIP Social Determinants of Health protocol**
   c. Medication Audit see **CIP Medication Audit protocol**
   d. Patients without a primary care provider and/or not enrolled in the CIP program **see CIP Program Enrollment protocol** and **see CIP Medical Direction protocol**
   e. Counsel/educate patient:
      1. Pathophysiology of disease/complaint
      2. When to call a health care provider
      3. Condition/complaint specific education **see applicable Care (treatment) and/or Complaint (treatment) protocol(s)**
   f. Develop a care plan/service plan for the patient **see CIP Patient Service Plan/Care Plan protocol**

VII. Document **see CIP Documentation protocol.**

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Treatment Protocol
DIABETIC CARE

Initial Date: November 19, 2020
Revised Date: Section 11-51

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide additional guidelines beyond the CIP General Assessment and Care for evaluating, caring for and educating patients with Diabetes.

I. Follow **CIP Patient General Assessment and Care protocol**
II. Obtain additional vital signs, history, and diagnostics pertinent to condition and/or as ordered by physician.
    a. Vitals: BGL
    b. History: Last oral intake, diet, medication changes and compliance
III. On-scene medication administration may include:
    a. Use of approved MCA protocols and medications up to the extent of standard paramedic treatment according to protocol.
    b. Assist with patient's prescribed home medications that are not included in standard EMS treatment protocols
    c. Use of patient's prescribed medications beyond the parameters of the prescription must have direct consultation with the referring physician prior to administration
    d. Oral high caloric fluid
    e. Oral glucose gel or tablets
    f. IV Fluid bolus of 0.9% NS maximum dose 2L
IV. On-scene education and suggested support sources may include:
        i. Diabetes Self-Management Education

MCA Name: Marquette Alger MCA
MCA Board Approval Date: 11/12/2024
MCA Implementation Date: 1/31/2025
Protocol Source/References:

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Treatment Protocol
ASTHMA CARE

Initial Date: November 19, 2020
Revised Date: Section 11-52

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide additional guidelines beyond the CIP General Assessment and Care for evaluating, caring for and educating patients with Asthma.

I. Follow **CIP Patient General Assessment and Care protocol**
II. Obtain additional vital signs, history, and diagnostics pertinent to condition and/or as ordered by physician which may include:
    a. Vitals: SpO2, work of breathing
    b. History:
        i. Frequency, duration, and triggers of DIB
        ii. Previous and recent episodes requiring treatment
        iii. Use of medications (short acting and long-acting corticosteroids, etc.)
        iv. Spirometry, peak flow, capnography
III. On-scene medication administration may include:
    a. Use of approved MCA protocols and medications up to the extent of standard paramedic treatment according to protocol.
    b. Assist with patient's prescribed home medications that are not included in standard EMS treatment protocols
IV. On-scene education and suggested support sources may include
    a. Review patient's current history including frequency of symptoms with rest, with activity and with sleep
    b. Review exacerbating factors including viral exposure, allergen exposure, exercise, cold air, tobacco smoke, chemical irritants, etc.
    c. Observe the home to identify exacerbating factors
    d. Review devices used by the patient including short/long-acting medications and MDI/continuous nebulizer devices
    e. Review when to call health provider
    f. National Certified Asthma Educator referral

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Treatment Protocol
CHRONIC OBSTRUCTIVE PULMONDARY DISEASE CARE
Initial Date: November 19, 2020
Revised Date: Section 11-53

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide additional guidelines beyond the CIP General Assessment and Care for evaluating, caring for and educating patients with COPD.

I. Follow **CIP Patient General Assessment and Care protocol**
II. Obtain additional vital signs, history, and diagnostics pertinent to condition and/or as ordered by physician which may include:
    a. Vitals: SpO2, work of breathing
    b. History:
        i. History of previous and recent episodes requiring treatment
        ii. Use of medications (short acting and long-acting corticosteroids, etc.)
    c. Diagnostics:
        i. Spirometry, peak flow, capnography
III. On-scene medication administration may include:
    a. Use of approved MCA protocols and medications up to the extent of standard paramedic treatment according to protocol.
    b. Assist with patient's prescribed home medications that are not included in standard EMS treatment protocols
IV. On-scene education and suggested support sources may include:
    a. Review patient's current history including frequency of symptoms with rest, with activity and with sleep
    b. Review exacerbating factors including viral exposure, allergen exposure, exercise, cold air, tobacco smoke, chemical irritants, etc.
    c. Observe the home to identify exacerbating factors
    d. Review devices used by the patient including short/long-acting medications and MDI/continuous nebulizer devices

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Treatment Protocol
CONGESTIVE HEART FAILURE CARE

Initial Date: November 19, 2020
Revised Date: Section 11-54

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide additional guidelines beyond the CIP General Assessment and Care for evaluating, caring for and educating patients with CHF.

I. Follow **CIP Patient General Assessment and Care protocol**
II. Obtain additional vital signs, history, and diagnostics pertinent to condition and/or as ordered by physician which may include:
    a. Vitals:
        i. Weight
        ii. Blood pressure with systolic and diastolic evaluation
        iii. SpO2
    b. History:
        i. Weight and blood pressure history and trends
        ii. Activity tolerance
        iii. Sleeping position
        iv. Recent DIB requiring treatment
        v. Medication use (diuretics, respiratory)
        vi. Spirometry, peak flow, capnography
III. On-scene medication administration may include:
    a. Use of approved MCA protocols and medications up to the extent of standard paramedic treatment according to protocol.
    b. Assist with patient's prescribed home medications that are not included in standard EMS treatment protocols
IV. On-scene education and suggested support sources may include:
    a. Salt and fluid intake discussion/counseling
    b. Review of proper device care and use: oxygen, diuretics, CPAP, and other medications being used for maintenance.

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Treatment Protocol
CHRONIC HYPERTENSION CARE

Initial Date: November 19, 2020
Revised Date: Section 11-55

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide additional guidelines beyond the CIP General Assessment and Care for evaluating, caring for and educating patients with chronic hypertension.

I. Follow **CIP Patient General Assessment and Care protocol**
II. Obtain additional vital signs, history, and diagnostics pertinent to condition and/or as ordered by physician which may include:
    a. Vitals:
        i. Manual and automated blood pressure
    b. History:
        i. Diet
III. On-scene medication administration may include:
    a. Use of approved MCA protocols and medications up to the extent of standard paramedic treatment according to protocol.
    b. Assist with patient's prescribed home medications that are not included in standard EMS treatment protocols
    c. Use of patient's prescribed medications beyond the parameters of the prescription must have direct consultation with the referring physician prior to administration
IV. On-scene education and suggested support sources may include:
    a. Salt and fluid intake discussion/counseling

POST MYOCARDIAL INFARCTION OR CARDIAC INTERVENTION CARE

Initial Date: November 19, 2020
Revised Date: Section 11-56

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide additional guidelines beyond the CIP General Assessment and Care for evaluating, caring for and educating patients with post MI or cardiac intervention care.

I. Follow **CIP Patient General Assessment and Care protocol**
II. Obtain additional vital signs, history, and diagnostics pertinent to condition and/or as ordered by physician which may include:
    a. Vitals/physical examination
        i. Evaluation of procedure specific incisions/wounds/dressings
    b. History:
        i. Enrollment and compliance with cardiac rehab services
III. On-scene medication administration may include:
    a. Use of approved MCA protocols and medications up to the extent of standard paramedic treatment according to protocol.
    b. Assist with patient's prescribed home medications that are not included in standard EMS treatment protocols
IV. On-scene education and suggested support sources may include:
    a. Cardiac rehab services referrals

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Treatment Protocol
POST ORTHOPEDIC SURGICAL INTERVENTION CARE

Initial Date: November 19, 2020
Revised Date: Section 11-57

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide additional guidelines beyond the CIP General Assessment and Care for evaluating, caring for and educating patients with post orthopedic surgical interventions.

I. Follow **CIP Patient General Assessment and Care protocol**
II. Obtain additional vital signs, history, and diagnostics pertinent to condition and/or as ordered by physician which may include:
    a. Vitals/physical examination
        i. Wound evaluation (redness, unexpected drainage, streaking)
        ii. Pulse, motor, sensation evaluation
        iii. Durable Medical Equipment (DME) use
    b. History:
        i. DME access and use
        ii. Activities of Daily Living (ADL) education and compliance
III. On-scene medication administration may include:
    a. Use of approved MCA protocols and medications up to the extent of standard paramedic treatment according to protocol.
    b. Assist with patient's prescribed home medications that are not included in standard EMS treatment protocols
IV. On-scene interventions and additional care may include:
    a. ☐ Suture Removal **see CIP Suture Removal protocol** (optional)
    b. ☐ Wound Care **see CIP Wound Care protocol** (optional)
V. On-scene education and suggested support sources may include:
    a. ADL assistance

MCA Name: Marquette Alger MCA
MCA Board Approval Date: 11/12/2024
MCA Implementation Date: 1/31/2025
Protocol Source/References:

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Treatment Protocol
POST STROKE CARE

Initial Date: November 19, 2020
Revised Date: Section 11-58

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide additional guidelines beyond the CIP General Assessment and Care for evaluating, caring for and educating patients with post stroke.

I. Follow **CIP Patient General Assessment and Care protocol**
II. Obtain additional vital signs, history, and diagnostics pertinent to condition and/or as ordered by physician which may include:
    a. Vitals:
        i. Blood pressure both automated and manual
        ii. Stroke scale re-evaluation
    b. History
        i. Use of memory aids and activity of daily living aids
III. On-scene medication administration may include:
    a. Use of approved MCA protocols and medications up to the extent of standard paramedic treatment according to protocol.
    b. Assist with patient's prescribed home medications that are not included in standard EMS treatment protocols
IV. On-scene education and suggested support sources may include:
    a. Support groups for both patient and family
    b. Use of DME
    c. Memory aids
    d. ADL assistance

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Treatment Protocol
PRENATAL CARE

Initial Date: November 19, 2020
Revised Date: Section 11-59

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

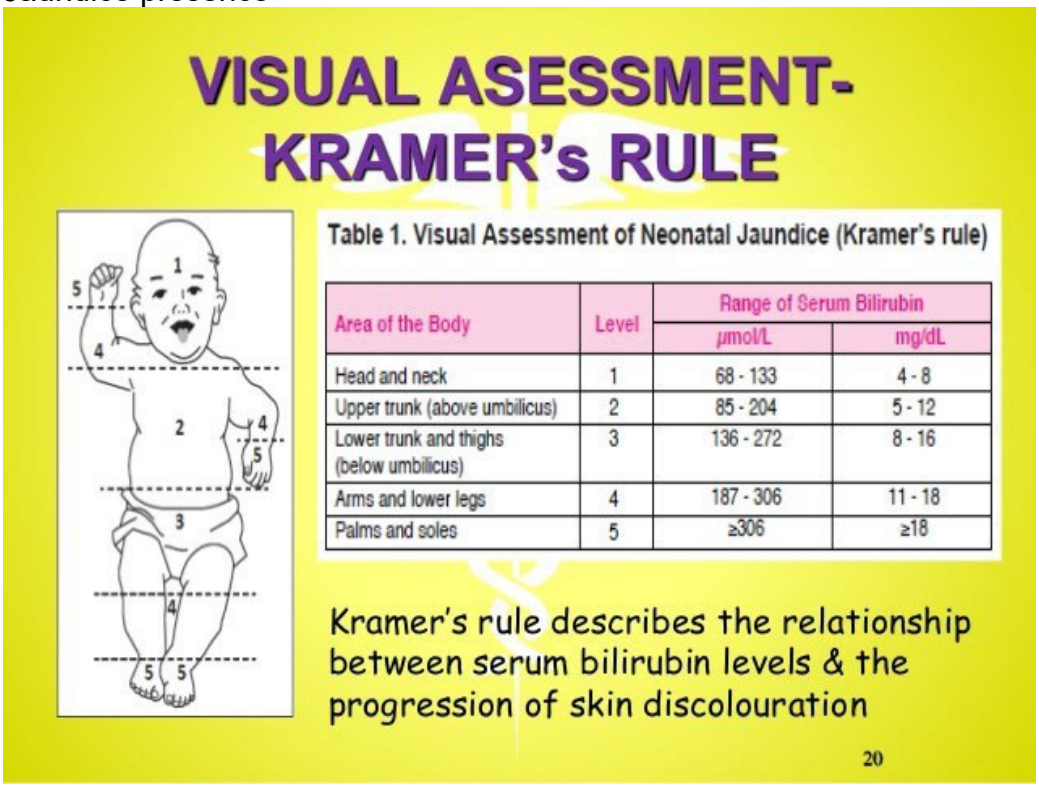
Purpose: To provide additional guidelines beyond the CIP General Assessment and Care for evaluating, caring for and educating patients and families who are pregnant.

I. Follow **CIP Patient General Assessment and Care protocol**
II. Obtain additional vital signs, history, and diagnostics pertinent to condition and/or as ordered by physician which may include:
    a. Vitals:
        a. Blood pressure both manual and automated
        b. Weight
        c. Fetal heart tones
        d. Fundal height
    b. History:
        a. Substance use current and past (tobacco, illicit, use and/or abuse of prescribed or non-prescribed)
        b. Domestic violence current and past
        c. Prenatal care history/compliance
        d. Vaginal bleeding
        e. Gestational diabetes
        f. Pregnancy induced hypertension or preeclampsia
        g. Postpartum depression
    c. Diagnostics:
        a. Depression screening
III. Care will not include vaginal examinations with the exception of impending delivery or hemorrhage
    a. Cervical and pelvic examinations to check for dilation are not permitted
IV. On-scene medication administration may include:
    a. Use of approved MCA protocols and medications up to the extent of standard paramedic treatment according to protocol.
    b. Assist with patient's prescribed home medications that are not included in standard EMS treatment protocols
V. On-scene education and suggested support sources may include:
    a. Nutrition and supplements
    b. Breastfeeding resources
    c. Postpartum depression support
    d. Newborn safety including:
        a. Safe sleeping recommendations/resource
        b. Car seat safety
        c. Infant CPR
        d. Shaken baby syndrome

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide additional guidelines beyond the CIP General Assessment and Care for evaluating, caring for and educating mothers and infants post- partum.

I. Follow **CIP Patient General Assessment and Care protocol**
II. Obtain additional vital signs, history, and diagnostics pertinent to condition and/or as ordered by physician which may include:
   a. Vitals/physical assessment:
      i. Mother
         1. Blood pressure both manual and automated
         2. Weight
      ii. Infant
         1. Weight
         2. Temperature
         3. Heart Rate
         4. Jaundice presence



   a. Adequacy of feeding
   b. Wakefulness/waking to feed
   c. Stool transition

b. History
    i. Mother
        1. Feelings of depression
        2. Eating, sleeping and self-care
        3. Complications with pregnancy
    ii. Infant
        1. Feeding habits
c. Environment
    i. Safe sleeping arrangement for infant
    ii. PEAT scale
d. Diagnostics:
    i. Depression screening

III. Consider transport to the emergency department for the following:
a. Infant temperature > or equal to 100.4 degrees OR < 96 degrees Fahrenheit as taken rectally.
b. Infant HR > 200.
c. Infant current weight less than birth weight minus 10%.
d. Maternal hemorrhage (use of greater than one maxi pad per hour)
e. Maternal signs of anemia with or without signs of external hemorrhage
f. Maternal signs of eclampsia

IV. On-scene medication administration may include:
a. Use of approved MCA protocols and medications up to the extent of standard paramedic treatment according to protocol.

V. On-scene education and suggested support sources may include:
a. Nutrition and supplements
b. Breastfeeding resources
c. Postpartum depression support
d. Newborn safety including:
    i. Safe sleeping recommendations/resource
    ii. Car seat safety
    iii. Infant CPR
    iv. Shaken baby syndrome

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Treatment Protocol
DIAGNOSED SLEEP APNEA CARE

Initial Date: November 19, 2020
Revised Date: Section 11-61

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide additional guidelines beyond the CIP General Assessment and Care for evaluating, caring for and educating patients with diagnosed sleep apnea.

Aliases: Obstructive Sleep Apnea

I. Follow **CIP Patient General Assessment and Care protocol**
II. Obtain additional vital signs, history, and diagnostics pertinent to condition and/or as ordered by physician which may include:
    a. Vitals/physical assessments/social assessments
        i. SpO2
        ii. Weight/BMI
        iii. Proper fit of mask
        iv. Quality of life score utilizing test used prior to diagnosis
    b. History:
        i. Sleep habits
        ii. Use of sleep aids (OTC, prescription)
        iii. Alcohol and drug use both recreational and self-medicating
    c. Diagnostics:
        i. Capnography
III. On-scene medication administration may include:
    a. Use of approved MCA protocols and medications up to the extent of standard paramedic treatment according to protocol.
IV. On-scene interventions may include:
    a. Adjustment of CPAP setting per referring physician's orders
V. On-scene education and suggested support sources may include:
    a. Equipment maintenance and use

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Treatment Protocol
WOUND CARE

Initial Date: December 14, 2020
Revised Date: Section 11-62

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide additional guidelines beyond the CIP General Assessment and Care for evaluating, caring for and educating patients with wounds.

Aliases:

I. Follow **CIP Patient General Assessment and Care protocol**
II. Obtain additional vital signs, history, and diagnostics pertinent to condition and/or as ordered by physician which may include:
   a. Vitals/physical assessment:
      i. Categorize, stage and measure wound when applicable

Stage	Description
Stage I	Non-blanchable erythema of intact skin
Stage II	Partial thickness skin loss; ulcer extends down to epidermis and/or dermis
Stage III	Full thickness skin loss; ulcer extends down to subcutaneous fat and fascia
Stage IV	Full thickness skin loss with extensive destruction and tissue necrosis; ulcer extends down to muscle, bone, tendon, or joint capsule

      ii. Location and extent of skin changes
      iii. Redness, drainage, weeping, ascending redness, warmth of skin, tract formation
      iv. Presence of pain
   b. History:
      i. Mechanism and duration of wound
III. On scene medication administration may include:
   a. Use of approved MCA protocols and medications up to the extent of standard paramedic treatment according to protocol.
IV. On-scene interventions may include:
   a. ☐ Suture Removal **see CIP Suture Removal protocol** (optional)
   b. Decontamination and cleansing of wound
   c. Wound closure utilizing wound closure strips
   d. Wound dressing
V. On-scene education and suggested support sources may include:
VI. Counsel/Educate
   a. ADL precautions

MCA Name: Marquette Alger MCA
MCA Board Approval Date: 11/12/2024
MCA Implementation Date: 1/31/2025
Protocol Source/References:

b. Self-administered wound care

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide additional guidelines beyond the CIP General Assessment and Care for evaluating, caring for and educating patients with Substance Use Disorder.

I. Follow **CIP General Assessment and care protocol**
II. Obtain additional vital signs, history, and diagnostics pertinent to condition and/or as ordered by physician which may include:
  a. Vitals/examinations:
    i. Site infections/wounds
    ii. COWs assessment/score
    iii. CIWA assessment/score
    iv. Signs of substance intoxication
    v. Oral health
    vi. Hygiene
  b. History:
    i. Evaluate risks for concurrent polysubstance use
    ii. Use history for prescribed medications and illicit substances
    iii. Intervention history
    iv. Immunization status
III. On scene medication administration may include:
  a. Use of approved MCA protocols and medications up to the extent of standard paramedic treatment according to protocol.
IV. On scene interventions may include:
  a. ☐ Vaccinations **see CIP Vaccination protocol** (optional)
  b. ☐ Wound Care **see CIP Wound Care protocol** (optional)
  c. ☐ Naloxone Leave Behind **see CIP Naloxone Leave Behind protocol** (optional)
  d. ☐ Medication Assisted Therapy (MAT) for Opioid Use Disorder **see CIP Medication Assisted Therapy protocol** (optional)
  e. Intervention resource referrals
V. Consider transport to the emergency department for the following:
  a. COWS score >36
  b. CIWA score greater than or equal to 9
VI. On-scene education and suggested support sources may include:
  a. Harm reduction/safer use education
  b. Syringe Service Program (SSP) opportunities

Protocol Source/References: https://img.grepmed.com/uploads/1565/withdrawal-diagnosis-addiction-opiate-scale-original.jpeg https://www.aafp.org/afp/2013/1101/p589.html

c. Risks of self-medicating
d. Withdrawal risks
e. Local resources

COWS Wesson & Ling, J Psychoactive Drugs. 2003 Apr-Jun;35(2):253-9.
Clinical Opiate Withdrawal Scale

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 Pulse rate 80 or below 1 Pulse rate 81-100 2 Pulse rate 101-120 4 Pulse rate greater than 120	GI Upset: *over last 1/2 hour* 0 No GI symptoms 1 Stomach cramps 2 Nausea or loose stool 3 Vomiting or diarrhea 5 Multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 No report of chills or flushing 1 Subjective report of chills or flushing 2 Flushed or observable moistness on face 3 Beads of sweat *on* brow or face 4 Sweat streaming off face	Tremor *observation of outstretched hands* 0 No tremor 1 Tremor can be felt, but not observed 2 Slight tremor observable 4 Gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 Able to sit still 1 Reports difficulty sifting still, but is able to do so 3 Frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds	Yawning *Observation during assessment* 0 No yawning 1 Yawning once or twice during assessment 2 Yawning three or more times during assessment 4 Yawning several times/minute
Pupil size 0 Pupils pinned or normal size for room light 1 Pupils possibly larger than normal for room light 2 Pupils moderately dilated 5 Pupils so dilated that only the rim of the iris is visible	Anxiety or irritability 0 None 1 Patient reports increasing irritability or anxiousness 2 Patient obviously irritable anxious 4 Patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 Not present 1 Mild diffuse discomfort 2 Patient reports severe diffuse aching of joints/ muscles 4 Patient is rubbing joints or muscles and is unable to sit still because of discomfort	Gooseflesh skin 0 Skin is smooth 3 Piloerrection of skin can be felt or hairs standing up on arms 5 Prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 Not present 1 Nasal stuffiness or unusually moist eyes 2 Nose running or tearing 4 Nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing Assessment:_____

Score: 5-12 mild; 13-24 moderate; 25-36 moderately severe; more than 36 = severe withdrawal

Protocol Source/References: https://img.grepmed.com/uploads/1565/withdrawal-diagnosis-addiction-opiate-scale-original.jpeg https://www.aafp.org/afp/2013/1101/p589.html

Patient: _____ **Date:** _____ **Time:** _____ **(24-hour clock, midnight = 00:00)**

Pulse or heart rate, taken for one minute: _____ **Blood pressure:** _____

NAUSEA AND VOMITING

Ask "Do you feel sick to your stomach? Have you vomited?" Observation.

0 No nausea and no vomiting
1 Mild nausea with no vomiting
2
3
4 Intermittent nausea with dry heaves
5
6
7 Constant nausea, frequent dry heaves and vomiting

TACTILE DISTURBANCES

Ask "Have you had any itching, pins and needles sensations, burning, or numbness, or do you feel like bugs are crawling on or under your skin?" Observation.

0 None
1 Very mild itching, pins and needles, burning or numbness
2 Mild itching, pins and needles, burning or numbness
3 Moderate itching, pins and needles, burning or numbness
4 Moderately severe hallucinations
5 Severe hallucinations
6 Extremely severe hallucinations
7 Continuous hallucinations

TREMOR

Arms extended and fingers spread apart. Observation.

1 Not visible, but can be felt fingertip to fingertip
2
3
4 Moderate, with patient's arms extended
5
6
7 Severe, even with arms not extended

AUDITORY DISTURBANCES

Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.

0 Not present
1 Very mild harshness or ability to frighten
2 Mild harshness or ability to frighten
3 Moderate harshness or ability to frighten
4 Moderately severe hallucinations
5 Severe hallucinations
6 Extremely severe hallucinations
7 Continuous hallucinations

PAROXYSMAL SWEATS

Observation.

0 No sweat visible
1 Barely perceptible sweating, palms moist
2
3
4 Beads of sweat obvious on forehead
5
6
7 Drenching sweats

VISUAL DISTURBANCES

Ask "Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.

0 Not present
1 Very mild sensitivity
2 Mild sensitivity
3 Moderate sensitivity
4 Moderately severe hallucinations
5 Severe hallucinations
6 Extremely severe hallucinations
7 Continuous hallucinations

ANXIETY

Ask "Do you feel nervous?" Observation.

0 No anxiety, at ease
1 Mildly anxious
2
3
4 Moderately anxious, or guarded, so anxiety is inferred
5
6
7 Equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

HEADACHE, FULLNESS IN HEAD

Ask "Does your head feel different? Does it feel like there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.

0 Not present
1 Very mild
2 Mild
3 Moderate
4 Moderately severe
5 Severe
6 Very severe
7 Extremely severe

AGITATION

Observation.

0 Normal activity
1 Somewhat more than normal activity
2
3
4 Moderately fidgety and restless
5
6
7 Paces back and forth during most of the interview, or constantly thrashes about

ORIENTATION AND CLOUDING OF SENSORIUM

Ask "What day is this? Where are you? Who am I?"

0 Oriented and can do serial additions
1 Cannot do serial additions or is uncertain about date
2 Disoriented with date by no more than two calendar days
3 Disoriented with date by more than two calendar days
4 Disoriented with place or person

Total CIWA-Ar score: _____
Rater's initials: _____
Maximum possible score is 67

Protocol Source/References: https://img.grepmed.com/uploads/1565/withdrawal-diagnosis-addiction-opiate-scale-original.jpeg https://www.aafp.org/afp/2013/1101/p589.html

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Treatment Protocol
SKIN RASH COMPLAINT

Initial Date: December 14, 2020
Revised Date: Section 11-75

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide guidelines for CIP paramedics to assess a patient with skin rashes, provide initial treatment and differentiate between the patients who will require ED evaluation vs. alternatives such as treatment on scene or alternative destinations.

Aliases: Hives, rash

I. Apply gloves prior to patient contact
II. Follow **CIP Patient General Assessment and Care protocol**
III. Obtain additional history and vital signs including the following:
   a. Time of onset, duration of complaint
   b. History of previous similar complaints and treatment required
   c. Presence of systemic symptoms: fever, chills, diaphoresis, weakness, dizziness, changes in mental status, breathing difficulty, chest pain, etc.).
   d. Location, size, and description of affected area
   e. Extent of skin changes
   f. Redness, drainage, weeping, ascending redness, warmth of skin, pain
   g. Presence of pain
   h. History of exposure oral (food/medications)
   i. History of exposure skin contact (poison ivy/oak, new products)
   j. Illness
IV. Consider transport to the emergency department for the following patients **see CIP Medical Direction protocol:**
   a. Suspected severe reactions such as Stevens- Johnson syndrome (SJS) or toxic epidermal necrolysis (TEN)
   a. Systemic symptoms
   b. Vital sign changes or instability
   c. Altered level of consciousness
   d. Ascending redness
   e. Presence of fever
V. On-scene medication administration may include:
   a. Use of approved MCA protocols and medications up to the extent of standard paramedic treatment according to protocol.
   b. Generalized itchy rash/pruritis
      i. Diphenhydramine 25-50mg PO/IM/IV
         1. Pediatrics: 1 mg/kg up to the adult dose
      ii. Steroids
         1. ☐ Methylprednisolone
            a. Adult 125 mg IV/IO
            b. Pediatrics 2mg/kg IV/IO (max does 125 mg)

2. ☐ Prednisone
   a. Adults and children over 6 years old 50 mg tablet PO
   iii. Monitor for changes and systemic symptoms after

c. Localized itchy rash (example: contact dermatitis, urticaria/hives, scabies)
   i. ☐ Hydrocortisone 1% topical ointment/cream treatment
   ii. ☐ Topical diphenhydramine

d. Other rashes
   i. If suspected zoster virus contact physician
   ii. If rash involves palms and soles, contact physician for consideration of possible syphilis or hand/foot/mouth disease
   iii. If suspected scabies contact physician
   iv. Rashes with changes or systemic symptoms contact physician

VI. Counsel/Educate
   a. Minimizing contact with allergen

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Treatment Protocol
URINARY COMPLAINT

Initial Date: December 14, 2020
Revised Date: Section 11-76

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide guidelines for CIP paramedics to assess a patient with a urinary complaint, provide initial treatment and differentiate between the patients who will require ED evaluation vs, alternatives such as treatment on scene or at alternative destinations.

Aliases: Urinary retention, painful urination, blood in urine, urinary tract infection

I. Follow **CIP Patient General Assessment and Care protocol**
II. Obtaining additional history and vital signs including the following:
   a. Time of onset, duration of complaint
   b. History of previous similar complaints and treatment required
   c. Presence of systemic symptoms: fever, chills, diaphoresis, weakness, dizziness, changes in mental status, breathing difficulty, chest pain, etc.).
III. Diagnostics to consider:
   a. Urinary Analysis urine dip stick (clean catch, straight catheterization, new/current Foley specimen) **see CIP Specimen Collection protocol**
   b. Urine Culture and Sensitivity
IV. Patients with any of the following, consider transport to ED **see CIP Medical Direction protocol:**
   a. Systemic symptoms
   b. Vital sign changes or instability
   c. Significant lab abnormalities
   d. Altered level of consciousness
   e. Signs consistent with sepsis **see sepsis protocol**
V. On-scene medication administration may include:
   a. Use of approved MCA protocols and medications up to the extent of standard paramedic treatment according to protocol.
   b. If urine is positive for infection, consider oral and/or IV antibiotics
      i. PO Antibiotics
         1. ☐ Cephalexin 500 mg. QID 3-10 days
         2. ☐ Trimethoprim/Sulfamethoxazole 160 mg/800 mg BID 5-10 days
         3. ☐ Ciprofloxacin 500mg. QID. 3-10 days. Note concern for tendonitis and tendon rupture after treatment
      ii. IV Antibiotics
         1. Per physician's order and supply
   c. Analgesics
      i. ☐ Phenazopyridine (Pyridium) 95 mg PO

ii. ☐ Acetaminophen PO (Max dose 650 mg)

iii. ☐ Ibuprofen PO (Max dose 600 mg)

d. If urine is negative for infection and urinary retention is suspected, consider urethral catheter insertion **see Urinary Catheter protocol**

VI. Counsel/Educate
a. Hydration
b. Pain management
c. When to contact a health care provider

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Treatment Protocol
GASTROINTESTINAL COMPLAINTS

Initial Date: December 14, 2020
Revised Date: Section 11-77

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide guidelines for CIP paramedics to assess a patient with gastrointestinal complaints, provide initial treatment and differentiate between the patients who will require ED evaluation vs, alternatives such as treatment on scene or at alternative destinations.

Aliases: Constipation, upset stomach, nausea, vomiting, diarrhea.

I. Follow **CIP Patient General Assessment and Care protocol**
II. Obtaining additional history and vital signs including the following:
    a. Time of onset, duration of complaint
    b. History of previous similar complaints and treatment required
    c. Presence of systemic symptoms: fever, chills, diaphoresis, weakness, dizziness, changes in mental status, breathing difficulty, chest pain, etc.).
    d. Presence of blood in stool or emesis
    e. Presence of pain
    f. Orthostatic vitals
III. Diagnostics to consider
    a. Urine pregnancy if available
    b. Electrolytes if available
    c. Blood Glucose
IV. Patients with any of the following, consider transport to ED **see Medical Direction protocol:**
    a. Systemic symptoms
    b. Vital sign changes or instability
    c. Presence of blood in stool or emesis
    d. Presence of abdominal pain or tenderness
    e. Altered level of consciousness
    f. Abnormal lab values
V. On-scene medication administration may include:
    a. Use of approved MCA protocols and medications up to the extent of standard paramedic.
    b. Fluid
        i. ☐ IV fluid bolus maximum up to 2 liters for signs of dehydration
            1. Caution with CHF and renal patients, consult physician prior to administration
    c. Nausea/Vomiting
        i. Ondansetron (Zofran) 4mg IV/IM
            1. Repeat one time if nausea and vomiting still present after 45 minutes

d. OR
   i. ☐ Ondansetron (Zofran) 4mg PO (ODT)
      1. Repeat one time if nausea and vomiting still present after 45 minutes

e. Pain
   i. ☐ Compazine 10 mg IM or slow IV push
      1. Lower dose for patients using other sedative medications
      2. Lower dose for elderly patients
      3.
         a. Monitor for dystonic reaction or akathisia
         b. Administer diphenhydramine 50 mg IV/IM
         If symptoms are not resolved within 20 minutes consider transport.
   ii. ☐ Acetaminophen 325 mg PO (Max dose 650 mg)
   iii. ☐ Ibuprofen 200 mg PO (Max dose 600 mg)

VI. Counsel/Educate
   a. PO recommendations
   b. When to contact a health care provider

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Treatment Protocol
SUSPECTED RESPIRATORY INFECTION COMPLAINT
Initial Date: December 21, 2020
Revised Date: Section 11-78

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide guidelines for CIP paramedics to assess a patient with suspected respiratory infection complaints, provide initial treatment and differentiate between the patients who will require ED evaluation vs, alternatives such as treatment on scene or at alternative destinations.

Aliases: Viral URI, cold, flu.

I. Follow **CIP Patient General Assessment and Care protocol**
II. Obtaining additional history and vital signs including the following:
   a. Time of onset, duration of complaint
   b. History of previous similar complaints and treatment required
   c. Presence of systemic symptoms: fever, chills, diaphoresis, weakness, dizziness, changes in mental status, breathing difficulty, chest pain, etc.).
   d. SpO2
   e. **Specimen and Collection protocol**
III. Patients with any of the following, consider transport to ED **see CIP Medical Direction protocol:**
   a. Systemic symptoms
   b. Vital sign changes or instability
   c. Presence of blood in sputum
   d. Presence of pain
   e. Altered level of consciousness
   f. Hypoxia on room air
   g. Presence of fever
IV. On-scene medication administration may include:
   a. Use of approved MCA protocols and medications up to the extent of standard paramedic treatment according to protocol.
   b. Fluid
      i. ☐ IV fluid bolus up to a maximum of 2 liters
         1. Caution with CHF and renal patients, consult physician prior to administration
   c. Antibiotics for suspected respiratory infection upon physician's orders.
      i. ☐ Azithromycin 250 mg tab PO. Two (2) on first day followed by 1 daily for 4 additional days
      ii. ☐ Doxycycline 100 mg tab PO, BID
   d. Antipyretics/Analgesics
      i. ☐ Acetaminophen 325 mg PO (Max dose 650 mg)

ii. ☐ Ibuprofen 200 mg PO (Max dose 600 mg)

V. Counsel/Educate
   a. PO recommendations
   b. When to contact a health care provider

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Treatment Protocol
SORE THROAT COMPLAINTS

Initial Date: December 21, 2020
Revised Date: Section 11-79

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide guidelines for CIP paramedics to assess a patient with an isolated sore throat without other respiratory complaints and differentiate between the patients who will require ED evaluation vs, alternatives such as treatment on scene or at alternative destinations.

Aliases: Sore throat, strep throat, croup

I. Follow **CIP Patient General Assessment and Care protocol**
II. Obtain additional history and assessment including the following:
   a. Presence of systemic symptoms: fever, chills, diaphoresis, weakness, dizziness, changes in mental status, breathing difficulty, chest pain, etc.).
   b. Detailed examination of the face, neck, mouth
III. Diagnostics to consider
   a. Strep test or other throat cultures per physician order **see Specimen and Collection protocol**
   b. Lab draw for blood tests (example: mono spot) per physician's order **see Specimen and Collection protocol**
IV. Patients with any of the following, consider transport to ED **see CIP Medical Direction protocol:**
   a. Systemic symptoms
   b. Vital sign changes or instability
   c. Significant lab abnormalities
   d. Altered level of consciousness
   e. Facial or neck swelling
   f. High fever
   g. Significant voice change "hot potato voice"
   h. Uvula deviation or swelling
   i. PO Intolerance
   j. Inability to swallow/drooling
   k. Fatigue
   l. Loss of appetite
   m. Body aches
   n. Chills
   o. Stridor
V. On-scene medication administration may include:
   a. Use of approved MCA protocols and medications up to the extent of standard paramedic treatment according to protocol.
   b. Fluid
      i. ☐ IV fluid bolus up to a maximum of 2 liters for signs of dehydration

1. Caution with CHF and renal patients, consult physician prior to administration

c. Antipyretics/Analgesics

i. ☐ Acetaminophen 325 mg PO (Max dose 650 mg) (optional)

ii. ☐ Ibuprofen 200 mg PO (Max dose 600 mg)

iii. ☐ Throat lozenges

d. Antibiotics for suspected strep upon physician's orders.

i. Strep

1. ☐ Penicillin V potassium 500 mg PO, QID. 7-10 days
2. ☐ Amoxicillin 500 mg PO, TID 7-10 days.
3. ☐ Cephalexin 500 mg PO, QID. 7-10 days
4. ☐ Azithromycin 250 mg PO , Two (2) tablets on the first day followed by 1 daily for 4 additional days
5. ☐ Amoxicillin/clavulanate 500 mg/125 mg PO

VI. Counsel/Educate

a. PO recommendations
b. When to contact a health care provider

Michigan
COMMUNITY INTEGRATED PARAMEDICINE
Treatment Protocol
NOSEBLEED COMPLAINT

Initial Date: December 14, 2020
Revised Date: Section 11-80

This protocol is for trained CIP Paramedics only. If during assessment, procedure, or treatment the patient is found to have a medical emergency in need of hospital treatment, the CIP visit will be suspended, and local MCA protocols utilized.

Purpose: To provide guidelines for CIP paramedics to assess a patient with a nosebleed, provide initial treatment and differentiate between the patients who will require ED evaluation vs, alternatives such as treatment on scene or at alternative destinations.

I. Follow **CIP Patient General Assessment and Care protocol**
II. On scene treatment for patients who are actively bleeding upon initial evaluation
    a. Have patient blow nose to remove clots
    b. Provide direct pressure to the nose for 10-15 minutes while preventing swallowing of blood as this may irritate the stomach
    c. CAUTION – if posterior source suspected at any time during treatment initiate 9-1-1 for immediate transport and begin/continue treatment
III. Obtaining additional history including the following:
    a. Time of onset of current nosebleed
    b. Mechanism or cause of nosebleed (use of oxygen without humidification, digital trauma, foreign body, spontaneous)
    c. History of previous nosebleeds and treatment required
    d. Use of medication which may affect treatment of nosebleed such as Aspirin or systemic anticoagulants (Lovenox, Coumadin, other novel oral anticoagulants, etc.).
    e. Presence of systemic symptoms: fever, chills, diaphoresis, weakness, dizziness, changes in mental status, breathing difficulty, chest pain, etc.).
IV. Diagnostics to consider
    a. Hgb
    b. PT/INR.
V. Patients with any of the following, consider transport to ED **see CIP Medical Direction protocol:**
    a. Significant trauma
    b. B. Continued bleeding despite treatment (consider possibility of posterior nosebleed) Systemic symptoms
    c. Vital sign changes or instability
    d. Significant lab abnormalities
    e. Altered level of consciousness
VI. On-scene medication administration and treatment may include:
    a. Use of approved MCA protocols and medications up to the extent of standard paramedic treatment according to protocol.
    b. If still actively bleeding provide direct pressure for an additional 10-15 minutes.
        i. Consider the administration of the following:
            1. ☐ Oxymetazoline (Afrin) 2-3 sprays in the affected nostril (medication is single patient use)

a. Do not use in patients less than 6 years old
b. Do not leave oxymetazoline (Afrin) with patient

ii. If bleeding is still active **see CIP Medical Direction protocol**
iii. Consider nasal packing see **CIP Nasal Packing and Nasal Packing Removal protocol**

c. Once bleeding has stopped consider the following for prevention of rebleeding

i. ☐ bacitracin
   1. Apply just inside the infected nostril
ii. ☐ saline ointment
iii. Saline nasal spray if available

VII. Counsel/Educate
a. Self-treatment options
b. Prevention

Sexual Assault Follow Up (Optional)

I. Indications

A. Patients who have had a sexual assault, do not have acute injury, and have been referred for follow-up.
B. Patients who have experienced a sexual assault and refuse transportation to the hospital or other follow-up resources but consented to CP follow-up.

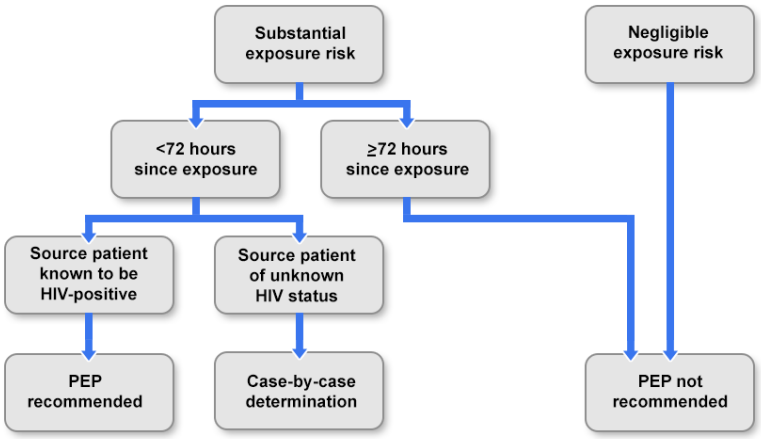
*NOTE: Providing a follow up care does not preclude other treatment protocols nor the need for transportation to an emergency department. Oxygenation, ventilation, and treatment of injury are the primary goals of treatment. Transport to a specialty facility or follow up with specialty care is preferred.

II. Procedure

A. Assess patient and treat according to Patient Assessment and other indicated protocols (if any).
B. Be sensitive to the patient's emotional state. Protecting the patient's privacy and respecting the patient's beliefs regarding emergency contraception must be prioritized.
C. Medications should be offered to appropriate patients who do not have other contraindications. The offer must include an objective explanation of the benefits and risks of use, as outlined in the medications being provided.
D. For patients at risk of sexually transmitted infections, regardless of timeframe:
    a. Administer ceftriaxone 500 mg IM
    b. Administer doxycycline 100 mg AND facilitate prescription for 100 mg BID for 7 days
    c. For male patients, administer metronidazole 2 g PO
    d. For female patients:
        i. Administer metronidazole 500 mg PO AND
        ii. Facilitate prescription for 500 mg PO BID for 7 days
    e. Access patient's vaccination status of HPV and Hepatitis B. If patient is not vaccinated, refer patient for vaccination.

E. For patients whose assault was within 72 hours:

a. Evaluate for HIV risk



SUBSTANTIAL RISK FOR HIV ACQUISITION

Exposure of
vagina, rectum, eye, mouth, or other mucous membrane, nonintact skin, or percutaneous contact

With
blood, semen, vaginal secretions, rectal secretions, breast milk, or any body fluid that is visibly contaminated with blood

When
the source is known to be HIV-positive

NEGLIGIBLE RISK FOR HIV ACQUISITION

Exposure of
vagina, rectum, eye, mouth, or other mucous membrane, intact or nonintact skin, or percutaneous contact

With
urine, nasal secretions, saliva, sweat, or tears if not visibly contaminated with blood

Regardless
of the known or suspected HIV status of the source

b. Advise patient of benefit of timely Post Exposure Prophylaxis (PEP) and follow up for 28-day prescription, along with referral to infectious disease clinic, if available.

F. For patients at risk of pregnancy, within 3 days (72 hours) of assault

a. If the CP has a religious objection to emergency contraception, offer information on emergency contraception. If the patient requests access to emergency contraception, facilitate access to emergency contraception.

b. Otherwise, offer emergency contraception, including risks and complications

i. Provide fact sheet to patient

ii. If patient consents, administer levonorgestrel 1.5 mg PO

iii. Advise patient that efficacy is greatly reduced if there is vomiting within 2 hours of taking medicine, and they should follow up with a physician if this happens

G. Document in Patient Care Record the education provided, medications administered, the patient's if any declination occurs, and referrals or specific resources offered to the patient.

H. Reiterate to the patient the need for follow-up care and remind of available resources, including:

   a. Sexual Assault Nurse Examiner or Sexual Assault Response Teams
   b. Any available literature for local resources