CP 4.12: Home Health Monitoring

Updated:
Reviewed:

Purpose

To support the Community Paramedic in using Community Paramedicine Home Health Monitoring (CPHHM).

Policy Statements

In response to a request for service from a health authority or primary health care provider, the Community Paramedic (CP) may enroll a patient into the CPHHM program. In the absence of an external referral, the CP may enroll the patient into the program, provided that:

1. There is no change in the frequency of patient visits without consultation from the patient's primary health care
2. CPHHM summary reports are made available to the patient's primary health care provider on a regular
3. The primary health care provider is made aware that the patient is enrolled in the CPHHM program

Eligibility

- **PATIENTS** >65 years old
- **PATIENTS** under the care of a Primary Health Care Provider
- **CONFIRMED DIAGNOSIS** of:
  - **HEART FAILURE** *(NB: Currently heart failure CPHHM is not offered in Interior Health's regional jurisdiction.)*
  - **COPD** (Chronic Obstructive Pulmonary Disease)
  - **DIABETES**
  - **PALLIATIVE**
- **COVID-19**
  - COVID-19 questions may also be added to any of the above HHM protocols, based on the clinical assessment of the Community Paramedic. These questions should be in addition to the patients own monitoring protocol. Patients with confirmed or presumptive diagnosis of COVID-19 should be referred to public health for monitoring.
- **SUITABILITY** assessment:
  - Willingness to participate in 3 months self-management program
  - Able to manage Home Health Monitoring equipment or has a capable caregiver
  - Understands and speaks English or has access to a translator
  - Can stand on a scale unsupported
  - Can follow written instructions
  - Can respond to questions and teaching over the phone
  - Has internet connection, or lives in an area with cellular service
  - Consents to participation in HHM Service
- **EXCLUSION** assessment:
  - Does not speak or understand English and has no access to a translator
  - Lives in a Residential Care Facility
    - However, residents of Assisted Living would be appropriate for enrolment
  - Lives outside of HHM Service geographical boundaries (if unsure, call the TELUS HHM service desk)
- **IF THE CLIENT IS NOT** eligible or suitable for CPHHM:
  - Notify originating referral source
  - May keep on CP caseload for regular CP services
  - Refer client to other services as required
- **IF THE CLIENT IS** eligible and suitable for CPHHM:

- Obtain HHM consent for participation in the HHM Service
  - Read the full consent form content to the client as required by Government of BC
  - If the client does not provide consent, consider the client unsuitable and follow the steps as listed above

Documentation

REPORTS may be printed from the Triage manager software, and should be delivered to the Primary Health Care Provider on a regular basis.

Patient Education Resources

1. BCEHS Community Paramedicine. Home Health Monitoring. [Link]
2. BCEHS Community Paramedicine. Home Health Monitoring Brochure. [Link]
3. TELUS Health. Someone to Watch Over Me. [Link]
4. TELUS Patient and Consumer Health Platforms. [Link]

References

1. American Heart Association. Classes of Heart Failure. [Link]
2. Michigan Institute for Care Management and Transformation. LACE Index Scoring Tool for Risk Assessment of Hospital Readmission [Link]