

INNOVATIONS IN PANDEMIC CARE

EMTs and paramedics expand traditional
roles in response to the COVID-19 crisis

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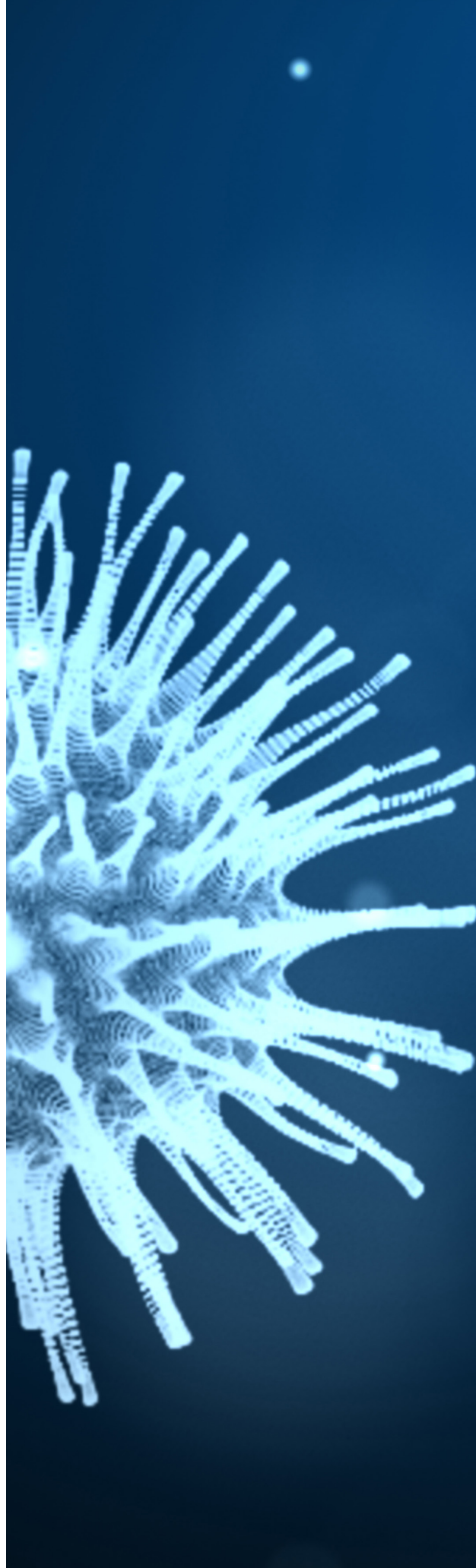
CONNECTING PATIENTS AND PROVIDERS THROUGH MODERN TECHNOLOGY

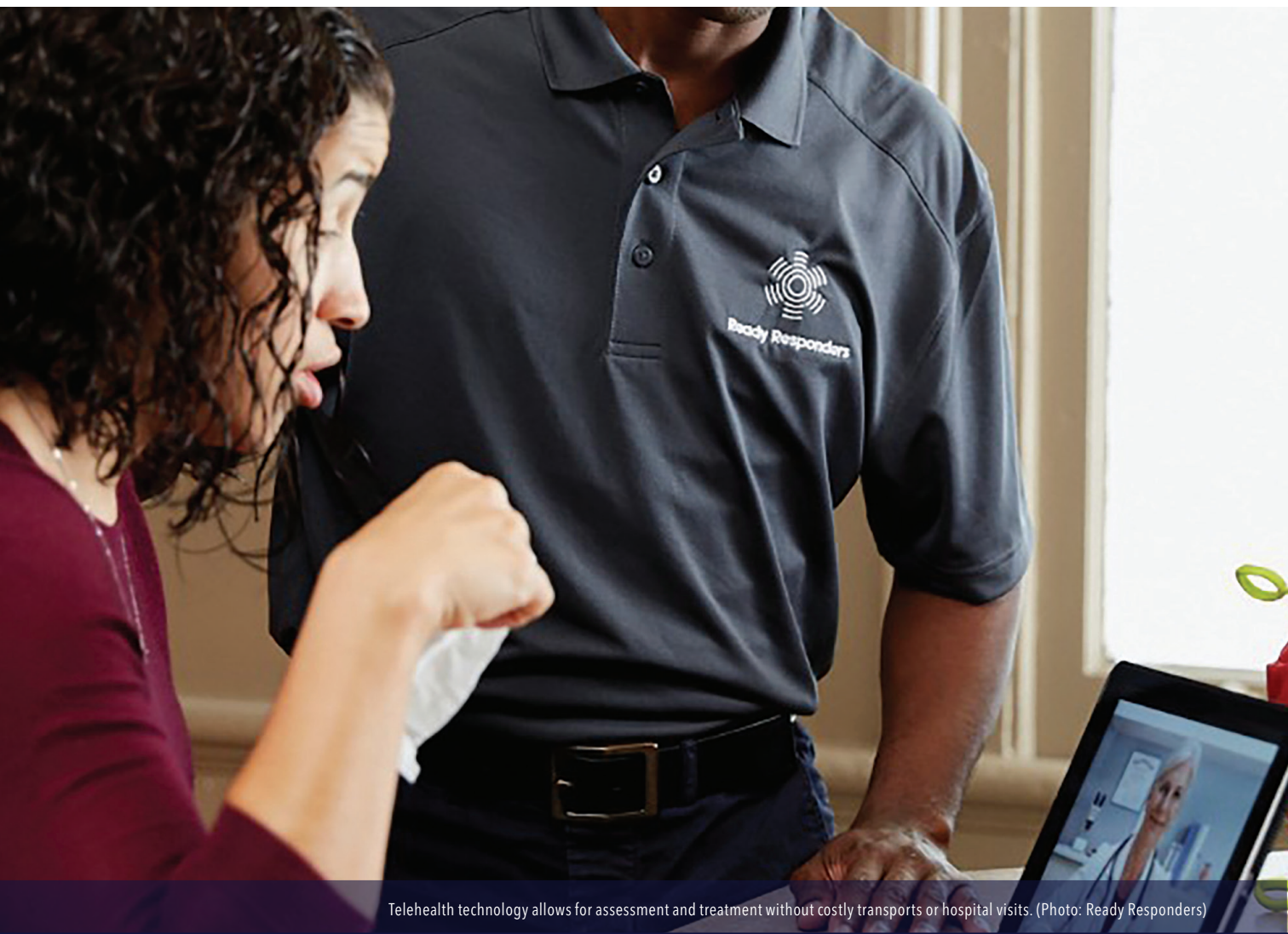
Throughout the country, the COVID-19 pandemic is overloading EMS systems with both emergency response calls and queries from the public on the severity of their symptoms, requests for wellness checks and questions about what to do if they or a loved one are suspected of having the disease.

The key to handling the crisis is patient-centered prevention and proactive community paramedicine programs to handle these calls without costly and time-consuming transports to the emergency department. This is where telemedicine comes in.

This special supplement produced in partnership between Healthcall and EMS World profiles forward-thinking EMS systems who are leveraging the power of telehealth and community wellness programs to circumvent traditional 9-1-1 response pathways. Through more efficient resource allocations, patients can be better served at a lower cost, both during the current COVID-19 pandemic and well into the future.

(All photos courtesy of HealthCall unless otherwise noted).





Telehealth technology allows for assessment and treatment without costly transports or hospital visits. (Photo: Ready Responders)

RELIEVING COVID DEMAND THROUGH AT-HOME PATIENT TESTING

By James Careless

The COVID-19 pandemic is putting intense pressure on medical centers and EMS in many ways, including the need to test potential COVID-19 patients for the virus. When performed at medical facilities, such tests expose health workers to the risk of coronavirus infection. If patients are transported to the hospital by ambulance, EMTs are put at risk too.

Healthcare service provider Ready Responders is reducing this risk to health workers and EMTs by providing COVID-19

testing to potential patients in their own homes by way of the company's app and website. Using initial telephone assessments, "Ready Responders screens patients before entering their home for COVID symptoms," says Olan Soremekun, MD, the company's chief medical officer. "If they screen positive, a responder—typically a certified nurse, EMT, or paramedic—will make a house visit in protective gear and set up a telemedicine visit with a clinician—typically a doctor, nurse practitioner, or physician assistant—who can order the FDA-approved

COVID-19 test."

The Ready Responders Platform

Available in Las Vegas and Reno, Nev. and southeastern Louisiana—with plans to expand to Washington, D.C., Columbia, Md., New York, Florida, California and Texas using \$48 million in just-acquired financing—Ready Responders is an on-demand, technology-enabled healthcare service that provides urgent care and nonemergency services in clients' homes or other

nonmedical locations.

“We accept all insurance, including Medicare and Medicaid, even if considered an out-of-network provider,” says Soremekun. “We bill the health plan, not the patient, as commercially reasonable. During the COVID-19 pandemic Ready Responders will not turn anyone away for not having insurance.”

The ability to call for telephone assessments and then book medical appointments at home means Ready Responders’ providers don’t have to go out into the community to get help. That has numerous benefits.

“This unique service platform helps

patients and payers avoid expensive and often unnecessary emergency rooms, outpatient clinics, and inpatient visits by sending specialized health professionals directly to patients wherever care is needed,” Soremekun says. “Ready Responders is able to combine telehealth technology with on-scene care to assess and treat the physical, mental, and social needs of the patient for less than a full-freight hospital or outpatient visit.”

Assessing Safety

Administering COVID-19 tests in patients’ homes is conducted under the direction of a qualified medical professional (as needed)

via telemedicine.

“Our responders are also capable of checking oxygen saturation levels for patients in the home, which can help guide triage,” says Soremekun.

Since EMTs may be called in to remove seriously ill COVID-19 patients from some of these homes, it is important for EMS and healthcare centers in Ready Responders’ areas to know about the company’s safety procedures for in-home coronavirus testing. According to Soremekun, these procedures are based upon solid training, relevant precautions, and access to the appropriate personal protective equipment.

When it comes to training, Ready

WEST PALM BEACH: LEVERAGING MOBILE TELEHEALTH TO ADDRESS COVID-19

Paramedics expand MIH-CP program to monitor and care for COVID-19 patients quarantined at home



With escalating concern of COVID-19 cases overwhelming regional hospitals, the Palm Beach County Fire Rescue (PBCFR) team in West Palm Beach, Florida was able to quickly expand their diversified mobile integrated health and community paramedicine (MIH-CP) program. Within a few short days the PBCFR team launched a comprehensive program to provide supplemental care and monitoring for COVID-positive patients at home.

Along with the team’s capacity to follow symptomatic patients, an invaluable skillset is their special training to care for patients with comorbidities who are also experiencing life challenges. Community paramedics and medical social workers go beyond assessing coronavirus symptoms to include medical, social, and emotional care as needed.

To support their unique care model, the HealthCall telehealth assessments were customized to add a medical social work component, which may grow in need as part of the secondary effects of COVID-19.

Patients can be screened for potential psychosocial needs; including mental health, food sufficiency, housing challenges, access to healthcare, unemployment, anxiety, depression, substance use, and other related social and functional determinants of health. Having the medical assessments related to COVID-19, as well as the social work elements, all in one place is critical for better care and operational efficiency.

“MIH is incredibly innovative and flexible by nature. We don’t operate within the same box of protocols that the front-line units adhere to. This work flow is going to serve patients well as we create new ways to innovate caring for significant numbers of vulnerable people at home, for now, via telehealth,” said Lauren Young, LCSW, medical social work coordinator of PBCFR.

Thanks to this mobile integrated health approach, the PBCFR team is able to scale-up and continue to make themselves available to quarantined-at-home patients, providing ongoing reassurance and advanced multidisciplinary care.

Responders' personnel are taught in compliance with all federal and state regulations, with a particular focus on infection prevention and control.

"We've conducted training specific to COVID-19," says Soremekun.

Precautionary practices used by Ready Responders personnel on site are monitored for compliance to prevent the spread of infectious agents. They include hand hygiene before and after patient contact, respiratory hygiene and cough etiquette, proper donning and doffing of PPE, and the cleaning of equipment, computers, and smartphones that enter the home.

"Ready Responders requires all respond-

ers complete a safety checklist before and after entering patients' homes," Soremekun says. "We have also added a daily responder temperature check at the beginning of each shift as an extra precaution."

A Timely Solution

The expansion of Ready Responders' coverage areas is good news for mainline healthcare workers and EMTs. After all, a person who is tested for COVID-19 at home is one fewer person requiring contact with mainstream medical personnel and consuming hospital/EMS resources. The more this happens across the United States, the better.

"In light of the COVID-19 pandemic, the

need for at-home health services is more important than ever to lower hospital and ER volumes and help free up beds," says Soremekun. "To keep vulnerable patients at home in quarantine, the healthcare industry must shift to more of an at-home and telehealth model to address patient needs. Ready Responders' platform has mitigated the need for many patients to go to ERs and hospitals to keep beds available for those who most need them, as well as helping reduce transmission by keeping those at risk at home, away from the most vulnerable as well as essential workers."

James Careless is a freelance writer and regular contributor to EMS World.

PLANO, TEXAS: COVID-19 SCREENING WITHIN DISPATCH VIA TELEHEALTH

Texas paramedics quickly launched telehealth video within dispatch to scale-up care and mitigate exposure



Paramedics in Plano, Texas, which is about 20 miles north of Dallas, braced themselves for a rush of COVID-19 9-1-1 calls by quickly implementing secure video telehealth capabilities to more effectively and efficiently screen patients.

New guidance protocols approved by the city were implemented for dispatch personnel to transfer COVID-19-related calls directly to onsite paramedics designated for triaging cases. Using telehealth-enabled care coordination software provided by HealthCall, paramedics implemented video conferencing services and installed cameras on their end.

Paramedics first talk with patients about possible COVID-19 symptoms by phone, and then to proceed with screening, by texting a link from the care coordination software. Patients simply click the link to launch a secure video session within seconds. They do not need to download an app or register to participate.

During the video session, paramedics ask the patient a series of questions about symptoms to determine their best care. When needed, paramedics can add physicians to the video session in

real time to discuss next steps, which may include in-home care without needing to transport them to a hospital emergency department. Under the city's new protocols and with physician supervision through telehealth, paramedics provide a higher level of care than previously possible.

Providing telehealth video within dispatch provides more immediate care and mitigates exposure, while alleviating the strain on emergency resources and hospitals. Patients are surprised by the program and very thankful to avoid going to the hospital.

All patient information is encrypted within the HealthCall system for secure data sharing with city and state health officials to more effectively coordinate response and mitigate the spread of COVID-19.

Plano, with a total population of about 280,000 people, had approximately 100 COVID-19 cases at the time of publication, and received between 5–10 COVID-19 9-1-1 calls daily. Telehealth video has proven to work so well in COVID-19 that paramedics plan to expand its applications to other EMS responses.

TESTING TESTING

Rejigged software speeds up COVID-19 screening in hard-hit communities

By James Careless

In a bid to get a handle on COVID-19, the Commonwealth of Massachusetts is testing residents and staff at nursing homes across the state.

EMS providers such as Fallon Ambulance Service have been recruited to administer these tests on site. Their EMTs have been taught how to perform nose swab tests and how to send that data to Quest Diagnostics, along with dropping off the test swabs at Quest afterwards.

Beyond the logistical and safety challenges associated with administering 800-2000 COVID-19 tests per day, Fallon Ambulance Service also has to enter the patient data it sends to lab partners into the EMS agency's own CAD system.

To say the least, completing this every day is time consuming. Fortunately, medical software provider Randseco has rejigged its online StatCall Patient Scheduling Portal so that EMTs only have to enter patient data once to inform the lab (Quest) and the CAD. As luck would have it, Fallon Ambulance Service has been using StatCall for scheduling patient transports for the past three years, so training its EMTs to use the new version was easy.

"Our rejigged StatCall platform—which we call our COVID-19 Testing Module—is saving Fallon Ambulance Service the equivalent of 17-20 data entry positions a day," said Michael Silk, Randseco's vice president of sales strategy. Just as importantly, this enter once/populate twice data entry model is providing Fallon Ambulance Service's CAD with patient information as soon

as it is being entered, rather than having to wait for someone to enter it after the fact.

"Being able to integrate our communications with Quest Diagnostics—with whom we have a great partnership—and our own CAD for reporting and billing is tremendous," said Peter Racicot, senior vice president of business development at Fallon Ambulance Service. "The fact that Randseco came up with this software solution in just a week is just as impressive."

How It Works

The heart of this COVID-19 data solution is Randseco's StatCall Patient Scheduling Portal. The original StatCall system allows EMS agencies to enter patient transportation information directly into their own CAD, along with any relevant customer-specific

PCS/Prior Authorization billing forms. Once the patient transport to hospital begins, StatCall provides EMS supervisors with regular updates about the ambulance's location and progress.

The COVID-19 Testing Module version of StatCall allows the EMT to record patient information and critical data points associated with the test—as mandated by the state government—on their smartphone, tablet, or PC. (These data points include patient name, race, gender, ethnicity, and whether they are COVID-19 symptomatic or asymptomatic.) This information is then transmitted directly to Quest Diagnostics or another lab testing agency, plus the EMS agency's CAD as well.

Not only does this dual filing save time, but it also eliminates the chance for data



Fallon Ambulance Service is administering COVID testing at nursing homes. (Photos: Fallon Ambulance)

LAS VEGAS: 500-BED FIELD HOSPITAL BUILT TO CARE FOR HOMELESS DURING COVID-19 CRISIS

City brings in nurses and volunteer medics to staff temporary field hospital built for homeless patients who may have COVID-19

A recent study ranked Las Vegas among the top 10 cities for homelessness. With a rate of 272 homeless individuals per 100,000 people, and given that this population remains very vulnerable to COVID-19, the city took steps to screen those at high risk for infection while also providing food and shelter.

Launched in April 2020, the City of Las Vegas opened an ISO-Q facility at the Cashman Center, just miles from downtown Las Vegas. Staffed with nurses and volunteer medics around the clock to screen and provide free COVID-19 comprehensive medical care to the homeless, the field hospital was among the first of its kind in the country as the outbreak began to spike in March and April.

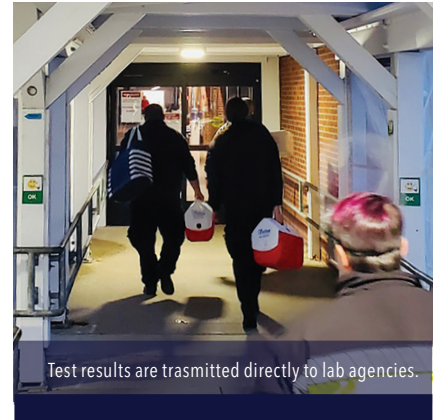
Healthcare providers walk the streets of Las Vegas, visit homeless encampments, and invite them to the field hospital for testing, medical treatment, a hot shower, a hot meal, and a bed. The goal is to identify potentially asymptomatic individuals as well as those who are experiencing symptoms, and to get them into quarantine as quickly as possible to help mitigate infection. Nurses and medics are fully equipped with protective gear. As incoming patients arrive, their clothes are fumigated and cleaned for them. Food and bathing facilities are provided, along with testing and medical care.

Nurses use cloud-based care coordination telehealth software provided by Health-Call that is custom-configured for COVID-19 screening and monitoring. This unique software platform allows care team providers at the ISO-Q facility to scale up quickly, assess and document patients' symptoms, and coordinate additional follow-up care electronically with area hospitals and physicians. Onsite screening at this field hospital also takes the pressure off regional paramedics and emergency room departments. All medical data is encrypted and shared with city and state health officials to more effectively coordinate response and mitigate the spread of COVID-19.

Clark County, home to Las Vegas, has a population of more than 2.2 million, and has reported more than 5,300 COVID-19 cases and nearly 300 deaths. People who live in homeless clusters or encampments are at high risk for unknowingly spreading COVID-19, or they may have symptoms but lack access to care.



Healthcare providers offer treatment to homeless populations.



input errors. As Randseco's website succinctly puts it, this approach makes the EMS agency's CAD "a single point of truth" for recording and storing COVID-19 testing information.

Useful Results

Given the high stakes associated with COVID-19, having a single point of truth when it comes to testing records matters. This applies to everything from individual patient treatment and tracking the spread of the disease throughout Massachusetts, to record-keeping and billing. With Randseco's COVID-19 Testing Module, everyone is on the same page.

A single point of data entry also provides Massachusetts with up-to-date testing information, because the commonwealth collects this data from Fallon Ambulance Service rather than Quest Diagnostics. "Rather than happening a few days from now, the data entry to Fallon's CAD is being done immediately," said Silk. "Everyone benefits from having access to this kind of data quickly."

Looking ahead, Randseco is ready and willing to offer its COVID-19 Testing Module to EMS agencies in other states.

"Massachusetts was very progressive in recognizing that there was a lack of knowledge about COVID-19 in their nursing homes, and tasking EMS to do comprehensive testing on site," Silk said. "As other states make the same decision, we'll be there to help them save time and improve data accuracy using our software solution."

James Careless is a freelance writer and regular contributor to EMS World.

CARING FOR COVID-19 PATIENTS WITH MOBILE INTEGRATED HEALTH

By Hilary Gates, MAEd, NRP

As the coronavirus pandemic continues to strain the entire healthcare system, one unique EMS specialty is being called upon to help: mobile integrated healthcare and community paramedicine (MIH/CP). While some MIH/CP programs in fire departments and EMS agencies are nascent and still finding their best fits for communities, many others are well-established and have improved patient care, lowered costs and improved overall population health.

EMS World talked with five leaders in the MIH/CP space about the issues facing their communities, what roles are best served by community paramedics, and what recommendations they have for how MIH/CP can serve during this pandemic.

Contributors

Daniel Gerard, MS, RN, NRP, EMS Coordinator for Emergency Medical Services for the Alameda Fire Dept., Alameda, Calif.

Anne Montera, MHL, BSN, RN, Public Health Consultant; President, Caring Anne Consulting, Gypsum, Colo.

Jonah Thompson, BA, NRP, CP-C, Mobile Integrated Health Operations Manager, Allegheny Health Network, Pittsburgh, Penn.

Michael Wright, NRP, MIH Manager, Milwaukee Fire Department, Milwaukee, Wisc.

Matt Zavadsky, MS-HSA, NREMT, Chief Strategic Integration Officer, MedStar Mobile Healthcare, Fort Worth, Tex.



EMS World: What role does MIH/CP have in the pandemic that is different than traditional EMS?

DG: Time is a constant that we battle against: trauma, cardiac, stroke emergencies. For the CP, the ability to spend more time with the patient is crucial. CPs have the opportunity and the time to assist with screening, vaccination, treatment, and follow-up. This is a boon especially for people who are on home quarantine or home isolation. The CP can make the house call and reach patients who have been typically underserved in the community. Some of our populations are medically fragile. Especially for those patients who are socially and economically disadvantaged, CPs provide a modicum of care that during this pandemic is sorely needed.

We should have an increased footprint in the community to perform public health screenings/fever checks, and when allowable, collect samples for screening services in order to diagnose COVID-19. When making a home visit, we should conduct a screening for every resident of the household for COVID-19, to include a fever check, health screening form and physical assessment (complaints of cough, fever, or sneezing; shortness of breath/difficulty in breathing of unknown etiology; past medical history; age; etc.).

This is an especially important activity if there is more than one at-risk individual who lives there. If within the CP's scope of practice, we should collect a swab/sample for COVID-19 for everyone who has signs and symptoms.

MZ: MedStar's medical director developed a process to effectively use the Medical Priority Dispatch System® (MPDS) to help manage low-acuity calls that may be COVID-related. MPDS has "Card 36" which is their Pandemic/Epidemic/Outbreak protocol. We have developed a process by which low-acuity Protocol 36 callers with the ability to access online resources are directed to a few web-based screening resources in our community. For low-acuity callers without the ability to access the internet, we will send a single-person resource (CP or other) to assess the patient and provide recommendations for further screening, if necessary.

However, we are currently in a payment conundrum: if we are going to begin the practice of not transporting many patients, we will not be paid for these calls. The whole country is having trouble with staffing right now due to so many factors; this is a perfect time for the Centers for Medicare and Medicaid Services (CMS) to say, "Let's start the ET3 pilot projects now and we'll do the paperwork later." Or to allow agencies to be paid for the A0998 HCPCS code (ambulance response, treatment and no transport) so agencies do not suffer a revenue loss while doing the right thing for the patient, and while they are helping to decompress the healthcare system.

JT: CPs are critical assets every day and even more so during a pandemic. Many frontline leaders may be tempted to see them as a pool of personnel available for surge capacity or to help cover gaps in the schedule. Not only would this be a disservice to these paramedical subspecialists, but it would also actively impede effective community response.

MIH/CP programs target the disproportionate utilization of healthcare services by our most clinically and socially vulnerable community members. The prototypical MIH/CP patient is likely to fall into one or more of the high-risk categories for infection with COVID-19 and development of COVID-19 illness.

Vulnerable and high-risk populations are more susceptible to difficulties associated with social distancing, commodity rationing, shut down of essential services including public transportation and community centers, exponentially magnifying the effects of any disaster. In a pandemic where measures may have to be implemented and maintained for weeks or months, our vulnerable neighbors are the second disaster waiting to happen.

We should work closely with case management and hospitalists. If large numbers of patients require hospitalization, most will get better and be discharged. Discharge and the decisions around when they can go home to continue to convalesce will be difficult. Based on many of the models available and the reported experience of our colleagues in Italy and elsewhere, the ability to discharge someone safely may be the difference for the patient who receives all possible interventions or is subjected to triaged care. CPs could be a key part of that process, ensuring a warm handoff and safe landing at home while addressing barriers to self-management.

How can MIH/CP be immediately utilized and/or how is MIH/CP already being utilized for the pandemic?

DG: CPs should be helping with screening/assessment of patients in long-term care facilities, skilled nursing facilities, daycare centers or in shelters for signs and symptoms suggestive of COVID 19. CPs should

be reaching out to the homeless to provide screening services where they happen to be if they are residing outside of a shelter and are undomiciled. Another opportunity for CPs is as a force multiplier for your occupational medicine staff. They are in the field every day, they can hold a 'sick-call' every shift change and screen staff for fever, cough, etc. and follow-up with staff who are sent home ill or who are on self-quarantine or self-isolation.

AM: All of the CPs in Eagle County, Colo. are on call to go perform COVID-19 testing. They are also following up on all of the telemedicine patients so that we give these patients a second set of eyes through the video platform to make sure they are doing okay.



MW: CPs should be helping with in-home or fixed-location testing. They should be conducting welfare checks on the elderly and assisting those with chronic disease who need medication refills.

MZ: Patients who are symptomatic and homebound could have a CP check in once or twice a day by phone or in person.

At MedStar Mobile Healthcare, our CPs recently began helping those with food insecurity or who are medically fragile. People are out of work and economically challenged, so we've done an outreach for these folks, establishing a relationship with food banks to deliver meals and food packets to vulnerable community members.

How are you using telehealth during the COVID-19 pandemic? What advice would you give to agencies who might want to expand or attempt the use of telehealth right now?

DG: We were not going to use telehealth as of yet because of HIPAA issues and because of the expense of the technology that would be required to be HIPAA-compliant. Since the Department of Health and Human Services (DHS) has suspended HIPAA compliance issues relevant to telehealth, this will allow us to now look at it in a different light and perhaps institute a simplified version at some point in the future.

AM: Last week, we developed a way for paramedics in three counties in Colorado (Eagle, Garfield and Teller) to use telehealth. When paramedics arrive to a patient who has symptoms of a respiratory illness, the providers stay in the ambulance, connect to the patient via text messaging and then on a downloadable telehealth app. They explain to the patient why they need to stay outside and then use the video telemedicine from the cab of the ambulance without needing to don any personal protective equipment (PPE) or enter the patient's home.

Paramedics monitor them through video and ask questions about their activities of daily living: how are they eating, staying hydrated, etc. all without physical contact or risk. At a cost of about \$200 per call for PPE, this saves money and resources.

If the patient needs immediate medical attention, then they don PPE and enter the home.

In Eagle County, the medical director put forth a protocol that allowed paramedics to assess patients via telemedicine with a head-to-toe "virtual" assessment on the app. Then based on their findings and expertise, the paramedics make that decision if they need to transport the patient.

What are the skills, knowledge, training and attitudes that MIH/CP providers can bring to support the health of the

public right now?

DG: A CP's ability to perform advanced assessments is paramount. The assessment and re-assessment are important tools on a longer trajectory to successfully manage a patient, over days, weeks, even years. CPs can spend the time determining patient needs and capabilities to manage their health at home, without the pressure of having 9-1-1 calls stacked up and dispatch asking CPs if they are available. Observing patients' living conditions, family interactions, home cleanliness and hazards, social structure, environmental issues, etc. help determine a patient's risk status.

JT: As paramedical practice continues to refine itself as a profession, we need to acknowledge that our subspecialists of CPs, Flight and Critical Care Paramedics, and others are best employed in their highly specialized roles. The value that these advanced clinicians bring to the entire continuum of care and healthcare system cannot be overstated.

MW: CPs have a unique ability to communicate complex issues to the people in terms that they will understand. The greatest enemy to thwarting any widespread issue is accurate, verifiable, and timely information. No different than firefighting—when the public runs away from the fire and we run towards it, MIH/CP has the same opportunity, especially when there is no emergency. There is a huge need for these skills.

MZ: I'd answer this question for those agencies that do not yet have an MIH/CP program: EMS agencies throughout the country are being asked to find ways not to bring every patient to the hospital or to find an alternative destination. More importantly, all of EMS needs to be invited to the table for these local and regional daily briefings and planning meetings. Get yourself to the table. This is a moment for EMS to positively impact communities.

Interviews have been edited and condensed for clarity.

Hilary Gates, MAEd, NRP, is the senior editorial and program director for EMS World.

NEW YORK CITY: IN-HOME COVID-19 TESTING AND CARE

Paramedics go door-to-door in public housing communities to help those who may lack access to screening and medical care

It's not easy reaching everyone at high risk for COVID-19 in a city as large and hectic as New York. Now over 100 paramedics are currently fanning out across the city's Housing Authority communities to visit low-income residents in their homes and screen individuals for potential illness. Wearing fresh Tyvek protection suits, an N95 mask, and safety goggles, these paramedics are part of a private venture working in cooperation with the city of New York.

Equipped with a stethoscope, a blood-oxygen gauge, a COVID-19 test, and a computer tablet, paramedics are going door-to-door in New York's public housing communities, which are often crowded apartment complexes where residents are vulnerable to disease transmission. In these communities, people who are under quarantine and who may have symptoms might not be seeking care but unknowingly spreading COVID-19.

Cloud-based telehealth and community paramedicine software by HealthCall is accessed to document COVID-19 symptoms and coordinate telehealth care with nearby physicians and nurses. All data is encrypted and shared with city and state health officials.

Paramedics screen the most symptomatic individuals in their homes. Those with more moderate symptoms are referred for follow-up care, whereas those with milder symptoms are monitored remotely. Between visits, protective gear including the Tyvek suit and mask are discarded; goggles and computer tablets are wiped down with disinfectant before moving on to the next apartment.

New York City is currently at the epicenter of America's ongoing COVID-19 crisis. Providing in-home care is easier for patients and helps remove financial barriers to accessing needed care. A bright side to this pandemic is how quickly people worked together to care for the vulnerable and those at risk.



Paramedics are screening for illness in Housing Authority communities.



Healthcare
made
practical

70 E. Swedesford Road, Suite 100, Malvern, PA 19355

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