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COMMUNITY PARAMEDICINE IN KANSAS

Policy Considerations for an Emerging Model of Care

Introduction

One emerging model of health care — community paramedicine — looks to provide a wide range of health care services in an individual's home, to increase access to care and improve health outcomes. This brief will explore the key policies and practices that influence, support or constrain community paramedicine programs.

What is Community Paramedicine?

Community paramedicine programs use the skills, experience and knowledge of emergency medical services professionals — most often paramedics and emergency medical technicians (EMTs) — to deliver a wide variety of non-emergency services outside of a hospital or clinical setting. In practice, this means community paramedicine programs look and operate in a variety of ways, depending on the specific laws, regulations, priorities and needs in each jurisdiction. At the highest levels, community paramedicine programs aim to expand access to care, improve patient outcomes and increase health care system efficiency by providing the *right care*, at the *right time*, in the *right place*. For community paramedicine programs, the right care is a wide range of health care services, the right time is before an emergency happens and the right place is in an individual's home.

Maximizing the Health Care Workforce

Some emerging models of health care seek to leverage a broader range of care team members to provide care outside of a clinical or hospital setting. Like many states, Kansas faces broad workforce shortages, particularly in rural areas where many hospitals are at risk of closure. In the face of these challenges — and others — policymakers and community leaders alike are looking for innovative approaches to improve patient outcomes and maximize health care system resources.

This is the second brief in a series exploring the role of expanded care team professionals in Kansas.

KEY POINTS

- ✓ Community paramedicine programs can expand access to care, improve patient outcomes and increase health care system efficiency and have shown promising effectiveness in both urban and rural settings.
- ✓ Community paramedicine utilizes trained emergency medical technicians (EMTs) and paramedics to provide health care services in a variety of non-emergency situations outside of a clinical setting.
- ✓ Laws and policies guiding community paramedicine programs build upon existing emergency medical services (EMS) laws and vary from state to state.
- ✓ In Kansas, community paramedicine is not explicitly defined or recognized in state policy and current services are provided under the existing EMT and paramedic scopes of practice.
- ✓ While most states, including Kansas, do not have reimbursement for community paramedicine services, a growing number are exploring reimbursement and recognition for community paramedicine.

Services Provided Through Community Paramedicine

Community paramedicine programs are tailored to meet the specific needs of the communities they serve, with most informed by a community needs assessment. Overall, the multitude of services community paramedicine programs provide can be organized into two categories: primary care and community coordination.

The primary care category focuses on preventing hospital readmissions and can include services such as in-home post-discharge care and chronic disease management for high-risk populations. Depending on training, program focus and state laws, community paramedics can be found providing fall assessment and prevention, checking blood pressure, providing immunizations, completing in-home electrocardiograms and ultrasounds, drawing blood, providing health education and completing medication reconciliation, among many other services. The community coordination category looks to connect patients with primary health care providers and services to address social needs. Referrals and navigation services often occur in this category. Additionally, community paramedics facilitate telemedicine appointments and support patients in connecting with mental health providers and social service resource sharing, such as local food banks and services for the unhoused. Importantly, the two categories of community paramedicine services can be complementary, as programs often provide services in both categories.

Defining Community Paramedicine

As defined by the National Association of Mobile Integrated Healthcare Providers, **community paramedicine** is "a segment of mobile integrated healthcare that is a provider-led, patient-centered delivery care model using appropriately trained Emergency Medical Service (EMS) clinicians in an expanded role to render care, facilitate a more efficient delivery of care, and enhance access to community resources that address the social determinants of health." While often used interchangeably or simultaneously, **mobile integrated health care (MIH)** is broader and can be defined as "a coordinated, patient centered, evidence-based, holistic model of care using collaborative, interdisciplinary teams to serve patient needs at the most appropriate level of care at a safe location of their convenience."

Who Provides Community Paramedicine Services?

Community paramedicine services are typically provided by paramedics, emergency medical technicians (EMTs), or first responders who work within emergency medical services (EMS) or other emergency response services, such as fire departments.

In most states, community paramedics are not separately licensed professionals, but rather are licensed EMTs or paramedics who complete additional training to become community paramedics. Notably, not all community paramedicine programs are staffed exclusively by paramedics, though some programs may require all their staff providing services to be paramedics. Additionally, some programs are staffed by a multi-disciplinary team of health care professionals. In Kansas, for example, the Olathe Mobile Integrated Health Team pairs a family nurse practitioner from a federally qualified health center with a fire department paramedic to deliver the program. In Eastern Missouri, the Washington County Ambulance District Mobile Integrated Healthcare Network integrates the skills of community health workers and community paramedics. While most often referred to as community paramedics, varying terminology is used for the professionals delivering community paramedicine services. Titles such as "advanced practice paramedic," "mobile integrated health clinician," "extended role paramedics" and others have been used to name the multifaceted approach to patient care that goes beyond

Alaska Community Health Aides/Practitioners (CHA/Ps)

First developed in the 1960s to meet health care challenges and needs in rural Alaska, the program is built upon cooperation between the federal and state governments and Native tribal health organizations. After being selected by a community, CHA/Ps are trained in emergency medicine skills at the EMT level and provide culturally relevant emergency, acute, chronic and preventative care that includes assessing and referring patients to the appropriate health care resources.

conventional emergency services. These differences can be seen between states, within research and academic settings, and in local jurisdictions. For example, while the state of Missouri certifies "community paramedics," the professionals delivering community paramedicine services within the Washington County (Missouri) Mobile Integrated Health (MIH) Care Network are referred to as "MIH clinicians." Furthermore, other programs, such as Alaska Community Health Aides/Practitioners (CHA/Ps), are distinct from community paramedicine, but are often included in discourse around the topic because they involve similar goals, workforce and services.

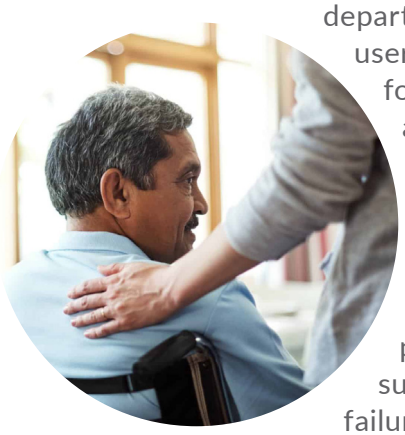
A Well-Positioned Workforce

Emergency medical professionals are accustomed to entering patients' homes, navigating changing and dynamic situations, and quickly building rapport and trust. They often are trusted and respected professionals who are welcomed into patients' homes. Additionally, the skill sets deployed in emergency treatment settings often translate to non-emergency care services.

In many situations, emergency medical professionals already respond to and provide services in non-acute situations. In 2022, 69.7 percent of EMS responses within the National Emergency Medical Services Information System were categorized as non-emergent, meaning most calls did not require an immediate response, as determined by local or state protocols.

Who Do Community Paramedicine Programs Serve?

The structure and setting of a community paramedicine program (e.g., hospital or fire department-based) — and the specific goal the program is trying to achieve — may influence who receives community paramedicine services. Common priority populations for these services include frequent EMS and emergency department (ED) users, those at risk for readmission and those with chronic disease management needs. Some programs have specific priority populations, such as heart failure patients who need follow-up care after emergency department treatment and discharge. Programs serving specific populations may have similarly narrow eligibility requirements. Additionally, some programs have broad geographic coverage — such as a multi-county region in a rural area — while others may cover a single municipality.



Community paramedicine programs have the potential to increase access to care for populations that otherwise may be underserved, across a variety of settings and locations. Patients with chronic disease, people who have difficulty leaving their homes to access care, and older or frail adults with increased fall risk all can be served through community paramedicine programs. Additionally, populations living in remote areas, including tribal populations, may benefit from care coming directly to their homes, supporting timely provision of care and avoiding long patient travel for services that can be provided outside of a clinical setting. Overall, community paramedicine programs serve populations that have identifiable service needs which can be

provided outside of a hospital or clinic setting, by health care professionals operating within their scope of practice.

How Effective Are Community Paramedicine Programs?

Though some community paramedicine programs have been operating for decades, scientific literature, much like the field, is still developing. Similarly, variations in program duration, focus, setting and outcomes make broad conclusions about effectiveness challenging. Additionally, the current literature base may be influenced by publication bias — where studies demonstrating positive results are more likely to be published. Several systematic reviews find the limited published literature on community paramedicine to be promising — with most studies reporting successful interventions — but emphasize the need for further, and more rigorous, evaluation and research to determine broad effectiveness and impact on health care costs and patient outcomes over time.

As the number of community paramedicine programs grows, and the research base expands, some specific areas of impact are gaining clarity. A 2023 exploratory meta-analysis of 12 studies published between 2000 and 2021 found community paramedicine programs were associated with a reduced risk of emergency department visits. Similarly, a systematic review of community paramedicine programs serving older adult patients, including 10 studies across Canada, the U.S. and the U.K., demonstrated evidence of positive effects for patient health, patient satisfaction and health care system utilization in most studies.

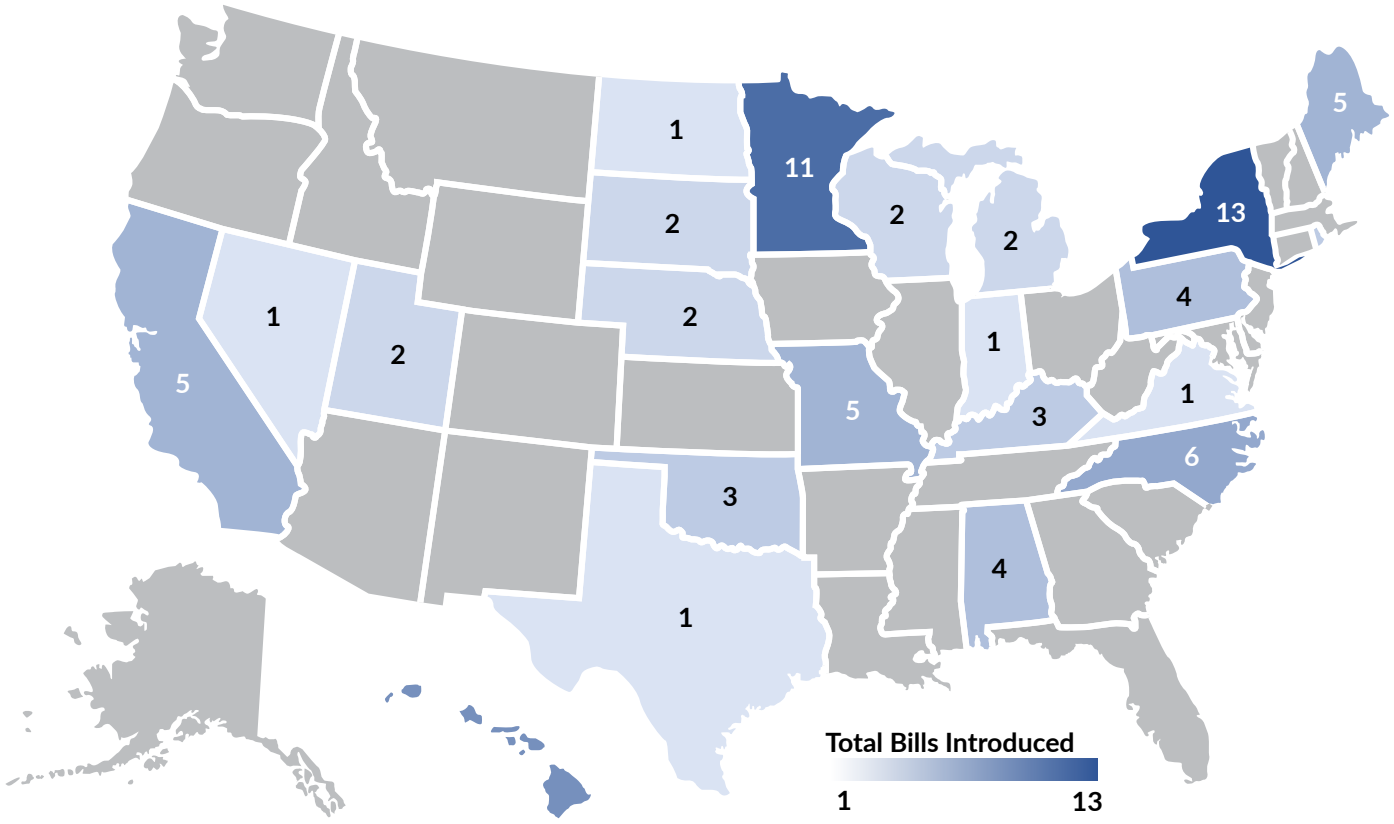
Pilot programs at the state level also offer an opportunity to evaluate community paramedicine across multiple sites and settings. In 2014, 13 projects across California were launched. While specific benefits and outcomes varied among sites, no adverse outcomes were identified that could be attributed to the projects, and other health professionals were not displaced. Key outcomes included reduced readmissions, cost savings for payers (primarily Medicare and Medicaid), decreased 911 calls and emergency department visits, and improved access to mental health services.

At the local level, community paramedicine programs in a variety of settings have documented positive outcomes among their participants. While specific results vary, successful outcomes in key measures such as readmissions, 911 calls and ED visits have been achieved — with some programs achieving 50 percent reductions over 12 months. Some programs also report reductions in health metrics such as blood pressure and blood glucose among program participants, albeit often with small sample sizes. Among programs with more developed data collection and evaluation systems, estimated cost savings can reach thousands of dollars per year from reduced ambulance use, emergency department visits and hospitalizations.

Encouraging Impacts in Rural Communities

Community paramedicine programs may have unique potential to improve health care access and outcomes in rural communities. A community paramedicine program in rural South Carolina significantly decreased emergency department and inpatient visits, while significantly improving blood pressure among patients with hypertension and blood glucose among patients with diabetes. In rural Central Oregon, a program among medically complex Medicaid beneficiaries who had a history of high emergency department utilization significantly decreased both overall emergency department use and avoidable emergency department visits.

Figure 1. **Community Paramedicine Scope of Practice Bills Introduced, 2015-Present**



Note: This map includes all introduced legislation categorized under "community paramedicine" within the National Conference of State Legislatures (NCSL) Scope of Practice Database. It includes legislation of all statuses — enacted, failed, failed-adjourned, override pending, pending, pending carryover, to governor, and vetoed.
Source: National Conference of State Legislatures, Scope of Practice Database. Data retrieved February 26, 2024. Available atncsl.org/health/scope-of-practice-legislation-database

Scope of Practice

The services a community paramedic may provide, and the role they play within a care team, are guided by their specific scope of practice. Scope of practice represents the actions a health care provider is allowed to take, as defined by their license and credentials, and through state law and regulation. The state-level actions needed to establish a scope of practice specific to community paramedicine depend on the existing laws and regulations that guide the scope of practice for EMTs and paramedics. In states with narrower scopes of practice for EMTs and paramedics, authorizing legislation may be needed for community paramedicine. In states where community paramedicine services fit within the existing scope of practice for EMTs and paramedics, including Kansas, statewide credentialing processes and administrative policy may help establish a scope of practice specific to community paramedicine.

Legislation and Statutes

State legislation and statute is one avenue through which states have worked to establish and refine community paramedicine scope of practice. States from coast to coast have introduced community paramedicine legislation over the last 10 years. Since 2015, at least 85 bills related to community paramedicine scope of practice have been introduced in 22 states (*Figure 1*). Of those 85 bills, 18 were enacted across 12 states.

Overall, states have taken four broad approaches to scope of practice for community paramedicine within statute. Notably, state laws for community paramedicine build upon the

The EMS Context

EMS is not an essential service in the United States, and the laws governing, regulating and organizing EMS vary from state to state. Existing state policies guiding, defining or specifying EMS services and scope of practice help set the legislative foundation and context for many community paramedicine statutes and regulations. Community paramedicine operates within and through the existing EMS framework within each state. In states that define EMS narrowly, additional legislation may be necessary to enable or meaningfully support community paramedicine programs.

existing EMS laws and regulations in the state — making the EMS context in each jurisdiction an important element of state policy opportunities and considerations.

- **Open:** Most states, including Kansas, do not have any specific scope of practice laws for community paramedicine. Community paramedics are not defined or recognized within state statute. In these states, health care professionals providing community paramedicine services do so within their existing scope of practice and practice guidelines as EMTs, paramedics or other professionals.
- **Extended:** In Iowa, Ohio and Washington, the controlling legislation does not specifically mention community paramedicine or other similar terminology for this group of health care professionals. Rather, legislation authorizes EMS to provide care and services in non-emergency situations. While these laws don't extend the number or types of services paramedics and EMTs can provide, emergency medical services have been extended to new situations.
- **General:** In states using a general authority approach, community paramedics are specifically defined and recognized in state statute, but specific services are not listed. In states like Missouri and Wyoming, community paramedics may provide any services that fit within their scope of practice, are authorized by the supervising medical director or care provider or are part of a care plan.
- **Specific:** Some states, including Minnesota, Nevada and Indiana, identify specific services that can be performed by community paramedics, as defined and recognized by the state. Example services listed within community paramedic scope of practice include health assessment, medication compliance, immunizations, referral to community resources and others.

Local EMS directors may be opposed to having specific scope of practice written into state statute or regulation, which would put a ceiling on the services that could be provided by the program, rather than allowing the medical director to make practice choices. "If you've seen one community paramedic program, you've seen one community paramedic program," is a saying that encourages programs to assess their specific community needs and build a program to fill those gaps, which can make it challenging for states to institute regulation and oversight.

Eligible Populations

Another aspect of the scope of practice for community paramedics is patient eligibility. As with other areas of community paramedicine policy, states differ in their approach. In Arkansas, the department of health has statutory authority to adopt rules related to emergency medical services. In the adopted rules, community paramedics are defined as "a paramedic that is licensed by the Department and provides care/services to patients not qualified for home health services or who are qualified but have rejected home health services; and meets all additional licensure requirements." The rules further define the services community paramedics may provide and the specific circumstances, and resulting populations, who are eligible for those services. In contrast, Wyoming, which utilizes a broad scope of practice and authority for its community paramedics — listed as community EMS technicians and clinicians — does not include eligibility criteria for patients in their administrative rule.

Medical Oversight

Medical oversight for community paramedics is often provided by the medical director for the ambulance service in which the program operates, or a partner health care organization, such as a federally qualified health center. In some settings, such as a hospital-based program, medical oversight may be provided by a hospital emergency physician or the primary care provider for the patient.

Medical directors can provide two types of oversight — on-line and off-line. On-line medical direction is guidance provided directly to community paramedics for service or care provision in the field. Off-line medical direction is administrative activity that defines, describes and enforces the training requirements, standards of care and operational procedures for a program and community paramedic. Both types of oversight, and the agencies in which they are based, help shape the services, policies and procedures guiding community paramedics.

Credentialling

Through credentialling, states may establish mechanisms to formally recognize and certify community paramedicine professionals' skills, knowledge and capabilities. As with other health care professions, formal recognition may be managed by different entities, such as state boards, agencies or non-governmental entities. Common credentialling mechanisms include:

- **Endorsement:** In states such as Colorado, Montana and Wyoming, community paramedics who complete the established training and education requirements are recognized at the state level. While endorsement does not create or authorize services beyond an existing scope of practice, it does serve as a verification and confirmation of skills and experience. In Kansas, a state community paramedic endorsement could likely be established by the Kansas Board of EMS under existing authority, without statutory changes. Kansas offers endorsements for other professions in addition to certification or licensure, from different state level entities. Examples include a building administrator endorsement for teachers from the Kansas Department of Education and an endorsement for nurses transferring licensure from another state from the Kansas Board of Nursing.

- **Certification:** Utilized by Minnesota, Missouri and others, certification eligibility and requirements may be written into state statute. These statutes may then authorize other agencies or bodies, such as the state board of EMS, to establish rules and processes for obtaining the certification. Like endorsement, certification allows states to verify and confirm skills and experience levels for community paramedics. Kansas certifies a number of professions, including community health workers, which are certified by the Kansas Community Health Worker Coalition, and case managers, nurse aides and peer mentors, which are certified by the Kansas Department of Aging and Disability Services.

- **Licensure:** In Arkansas and Tennessee, community paramedics are formally recognized through licensure. Like endorsement and certification, licensure offers a way to certify and confirm skills and experience. However, licensure generally requires statutory change to establish. Additionally, establishing a new license within a state may create a ceiling for authorized activities for existing paramedics or EMTs. Licensed professions in Kansas include doctors, physical and occupational therapists, dentists and registered nurses.

Across the three mechanisms for formal recognition of community paramedics, states often impose one or more requirements, such as an active EMT or paramedic license, specified years of experience, completion of an approved training program and completion of an approved examination.

Education & Training Requirements

Education and training requirements for individuals providing community paramedicine services vary by program and jurisdiction. In some cases, foundational requirements may be written into statute, regulations and credentialling. In other states, training and education requirements

are determined by individual local EMS bureaus. Additionally, some states — like Kansas — do not have any state-established community paramedic training and education requirements. Regardless of state statutes and regulations, individual programs may require additional or specific training and education for their service.

Training and Education Resources

Community paramedic training and education is available nationwide through various schools and agencies, typically involving both classroom and clinical experiences. The Community Healthcare Emergency Cooperative, an international group of agencies, colleges and universities that guides the ongoing development of the North Central EMS Institute's Community Paramedic curriculum, offers a standardized curriculum at no cost to colleges and universities, catering to different levels of community paramedic roles based on the highest level of education completed. Some states, such as North Carolina, have provided subsidies to allied health programs in community colleges — a subsidy that is available for students across state lines.

While optional in most states, community paramedics can pursue certification through the International Board of Specialty Certification (IBSC) to become recognized as a certified community paramedic (CP-C). To qualify for IBSC certification, individuals must hold an unrestricted license to practice as an EMT, paramedic or other nursing or community health worker with appropriate education and training. In rural areas where funding and time constraints may limit certification options, EMTs may receive training as primary care technicians or community EMTs (C-EMTs).

Financing

Historically, federal and state laws have categorized EMS as a transportation provider and, as a result, payment, funding or other reimbursement has been tied to patient transport, not patient care. While shifts in state policy, combined with efforts to integrate EMS into health care systems, have created new opportunities for community paramedicine programs, funding and reimbursement remain a chief concern and limiting factor for the growth and sustainability of these programs.

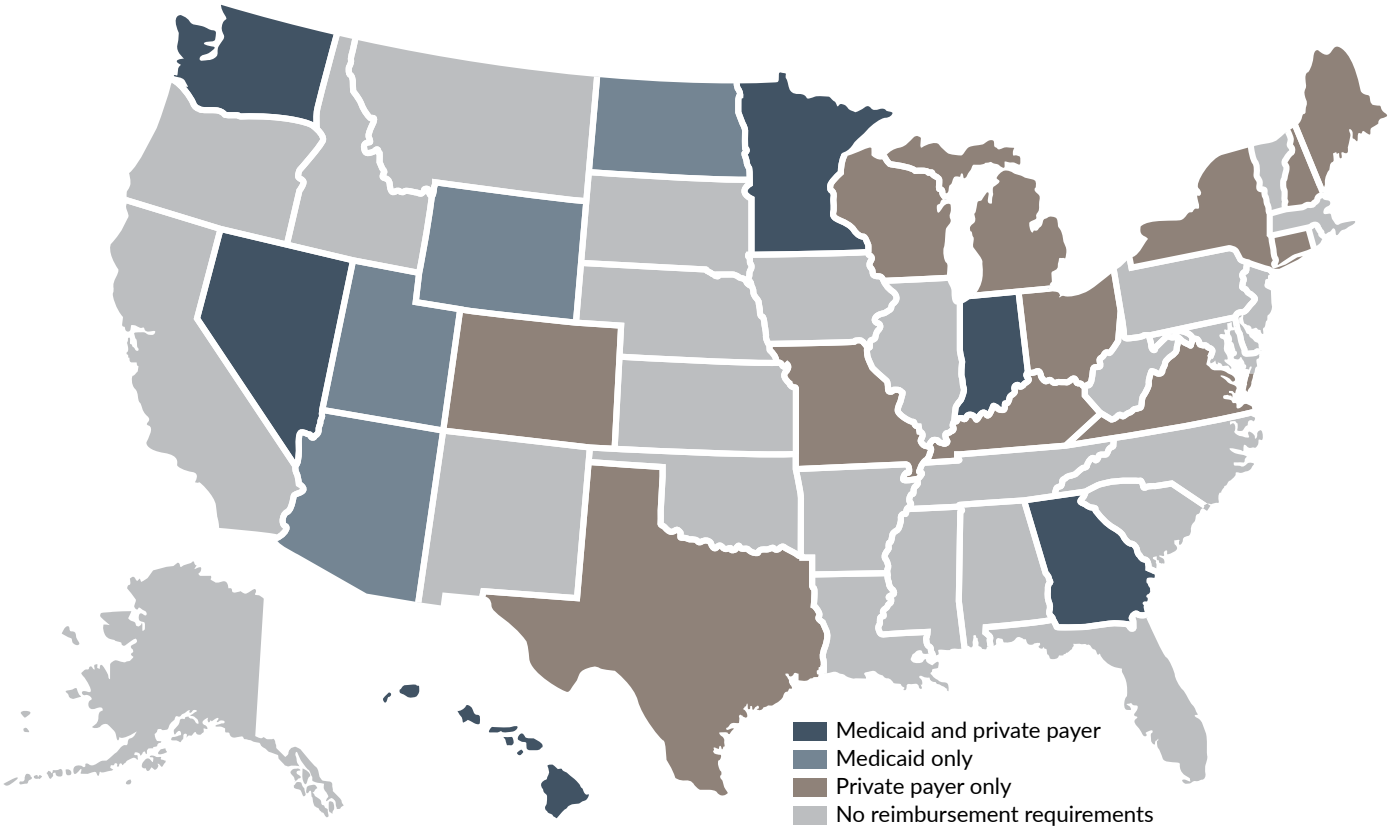
In 2018, a national survey of mobile integrated health and community paramedicine programs (MIH-CP) was conducted by the National Association of EMTs. Overall, one-third of MIH-CP programs agreed or strongly agreed their program was financially sustainable. However, 89 percent of program respondents agreed or strongly agreed that reimbursement or funding were significant obstacles for their MIH-CP programs.

Tools for Financing Community Paramedicine

There are numerous financing sources for community paramedicine, ranging from one-time donations to statewide public payer reimbursement. These financial sources often are grouped into two categories — programmatic funding that is typically short-term and unstable, and reimbursement for services that is predictable and sustainable.

The many financing approaches for community paramedicine can be viewed as a continuum of complexity and sustainability. On one side, programmatic funding approaches, though not sustainable sources, can be implemented relatively quickly without involving policy makers or changing laws and regulations. In contrast, while reimbursement pathways offer an accessible and sustainable financing pathway

Figure 2. **Reimbursement Policy for Community Paramedicine Services, 2022**



Source: California Health Care Foundation (2019) & National Conference of State Legislatures (2022). Data retrieved April 15, 2024. Available atncsl.org/health/beyond-911-expanding-the-primary-care-role-of-first-responders-through-community-paramedicine

for community paramedicine, they are outside of the direct control of individual programs.

While each financing tool may be described in isolation, in practice, individual community paramedicine programs may consider and utilize multiple approaches. Taken together, the various financing approaches are tools for initiating, sustaining and growing community paramedicine programs — each with their own strengths and limitations. Ultimately, the available financial tools at the disposal of individual community paramedicine programs are shaped by the specific setting and structure of the program, and the policy environment for the jurisdiction.

Programmatic Funding

While reported start-up costs for community paramedicine programs vary significantly, financial resources must often be mobilized or secured to launch a new community paramedicine program. In some cases, a single source of funding, such as a large grant, may be sufficient to start a program. In other cases, multiple sources of funding are layered together to cover the costs of the program. Key potential sources of programmatic funding include:

- **Self-Funding:** For some EMS agencies, community paramedicine programs may be developed using their own resources. A county-based ambulance service may choose to cover the costs of a new community paramedicine program with existing tax funding already included in its budget. In some cases, the additional costs associated with a community paramedicine program may be covered by cost savings elsewhere in the organization. Hospital-based ambulance services, for example, may provide financial support for their community paramedicine programs with the expectation that they can ultimately generate cost savings through reduced costs elsewhere, such as unreimbursed emergency care.
- **Pilots and Grants:** Multiple entities, at the local state and federal level, may provide

grant funding for community paramedicine programs and services. While these funds may help cover start-up costs and provide operational funding for a period, they are not sustainable sources. Additionally, services or jurisdictions may compete for the same limited funds, thereby limiting the reach of grant-funded community paramedicine programs. Similarly, state offices of rural health, and other state agencies, may launch pilot programs to provide seed funding, technical assistance and other support to explore and implement community paramedicine programs. The Medicare Rural Hospital Flexibility Program (Flex), established by the federal Balanced Budget Act (BBA) of 1997, provides grants to states to strengthen rural health care infrastructure through the establishment of rural health networks, regionalization of rural health services and improved access to health services for rural residents. An optional program area for Flex funding involves improvements for rural emergency medical services.

- **Provider Partnerships:** As health care provider payment models shift toward accountability for patient outcomes, partnerships between community paramedicine programs and a broad set of health care providers have become another financing approach. Hospital-based ambulance services may be particularly well suited to explore these opportunities. A common goal of such programs is to improve chronic disease management and reduce readmission rates. When savings are generated, a shared savings arrangement may pass some of the funds to the community paramedicine program. When the partnership no longer serves all sides, however, the arrangement may end — limiting the sustainability of such partnerships.

Reimbursement and Related Financing Approaches

Compared to programmatic funding options, reimbursement for community paramedicine services, whether through public or private payers, offers a more sustainable mechanism to pay for community paramedicine services. However, authorizing legislation or appropriations are often required at the state level to create pathways for reimbursement, whether from public or private payers. As of 2022, at least 21 states require some public or private payer reimbursement for community paramedicine services (*Figure 2*, page 9).

In some markets, provider reimbursement has been shifting from fee-for-service to value-based models, which ties a portion of payment to the quality of care delivered rather than quantity of services provided alone. Organizations that can provide quality community-based care, such as community paramedicine programs, could prevent more costly service needs or the need for hospital transfers, which may be of interest to payers.

In addition, a developing strategy for reimbursement is cost-avoidance, or shared savings, which allows a community paramedicine program to earn a portion of the savings generated from reduced hospital admissions, if the patient is not readmitted within a 30-day window. While this is mainly being developed in urban areas, both rural and urban communities have explored related pilot projects including bundled payments and at-risk payment arrangements. For example, Colorado's Eagle County Ambulance District has an agreement with a local hospital to recover a share of the savings achieved from readmission prevention efforts. MedStar in Fort Worth, which is currently reimbursed through a "fee-for-referral" model, is negotiating a shared savings model with hospitals, hospice organizations and an accountable care organization (ACO) that collaborates with a

Facilitating Third Party Reimbursement

To facilitate reimbursement for community paramedicine services from insurers, some companies are beginning to offer services to establish partnerships with payers to reimburse EMS agencies for visiting their "high utilizer" members. Under this program, these companies will work with EMS agencies that want to build a community paramedicine program, help them develop their programs, attain patients and secure payment from insurers.

managed care organization (MCO) on risk-sharing agreements, to divide savings with the hospitals in an 80/20 split.

An opportunity may exist to hold discussions with payers around contracts that could include community paramedicine, especially as states negotiate contracts with MCOs. For example, the New Mexico Human Services Department collaborated with its MCOs to reduce non-emergent emergency department visits, using several different strategies, including community paramedicine, to address the initiative. In Kansas, the KanCare Request for Proposals released in 2023 specified that MCOs should propose value-added services to expand the care team and required MCOs to enhance their care coordination model and invest some of their profits in communities. Those expectations may provide an opportunity for MCOs to invest in community paramedicine, including through amendments to awarded contracts.

A few states, Minnesota being the first, provide reimbursement for community paramedicine services in their Medicaid programs. By 2022, additional states in various regions of the country, including Arizona, Georgia, Hawaii, Minnesota, Nevada, Wyoming and others, began providing Medicaid reimbursement for these services.

Some states provide reimbursement for particular aspects of community paramedicine, such as EMS treatment of patients without transport to an emergency department.

Section 1115 Waivers and State Plan Amendments could allow more states to explore additional reimbursement options. For example, states have the option to propose a State Plan Amendment that acknowledges paramedics as providers of on-scene services without transport. They can also adjust state policies limiting emergency transport destinations and apply for waivers related to operating statewide (statewideness), comparability of services and freedom of choice requirements, all of which could allow regional or pilot solutions tailored to their community paramedicine program design.

Health Care System Integration

Health care system integration is a key component of effective and sustainable community paramedicine programs. Community paramedicine programs often work collaboratively with other care team members, such as community health workers and home health nurses, and partner organizations and agencies such as federally qualified health centers. Referrals to and from community paramedicine programs are common and connect to a range of partner organizations, including hospitals, home health agencies, law enforcement, social service agencies and others. Through referrals and organizational partnerships, community paramedicine programs can be complementary to other home-based and community-based care efforts.

Settings and Organizations

Community paramedicine programs operate in a variety of settings, within both public and private agencies. In the most recent national survey of mobile integrated health and community paramedicine programs, the most common delivery model among respondents was based out of a fire department, followed by services based out of a hospital. Additional agency types include private nonprofit, private for-profit, public regional, public city and public utility. In addition to the variety of delivery models, community paramedicine programs serve jurisdictions and service areas with a wide range of population sizes, and in urban, suburban and rural settings.

In addition to formal community paramedicine programs, community paramedicine services may be provided outside of established programs, by paramedics, EMTs or first responders practicing within their professional scope. For example, an EMT who responds to a 911 call for a fall, and who identifies and removes the hazard in the home leading to the fall, is providing a service that could be categorized as community paramedicine.

Data Collection and Evaluation

Community paramedicine programs operating within the EMS system must follow state and federal EMS reporting requirements and regulations. These requirements are guided by the National Emergency Medical Services Information System (NEMSIS), which serves as the national database for storing EMS data from states and territories. In 2022, all 50 states and the District of Columbia submitted national data to NEMSIS. States also may elect to have additional data elements collected at the state and local levels. States that seek to create reimbursement pathways, such as through Medicaid, also may have additional data collection needs and requirements.

In addition to EMS-required data collection, specific services may have their own data collection protocols or approaches. The National Association of Emergency Medical Technicians has developed a measurement strategy guide for mobile integrated health care programs. The "Big Four" measures deemed necessary for a "bona-fide" mobile integrated health care or community paramedicine program are ambulance transport savings, hospital ED visit savings, all-cause hospital admissions savings and total expenditure savings. Hospital-based community paramedicine programs may enable community paramedics to chart directly into a patient electronic health record alongside other care team members. Data sharing between hospitals, clinics and other health care providers and community paramedics may support more precise care provision.

Conclusion

Community paramedicine is a dynamic approach aimed at expanding access to care, enhancing patient outcomes and optimizing health care resource utilization. The effectiveness of community paramedicine is supported by emerging evidence, demonstrating reductions in emergency department visits, readmissions and health care costs, alongside improvements in patient health and satisfaction. Pilot programs across various states underscore the potential for positive outcomes and cost savings, reinforcing the value proposition of community paramedicine within the broader health care landscape.

Health care service duplication and competition is one of the key concerns community paramedicine programs may face as they initiate development. By designing the programs around the specific needs and assets of a community, these programs can avoid duplication of and competition with other health care professionals. Failing to clarify the unique roles, scopes and services provided by community paramedics can lead to resistance and tension with other health care professionals.

Determining the full potential of community paramedicine requires consideration of key policy factors such as scope of practice, medical oversight, training requirements and funding mechanisms. Variations among state-level policies underscore the need for ongoing dialogue and collaboration among policymakers, health care providers and community stakeholders. Efforts to integrate community paramedicine with existing health care systems will require a shared commitment to improving health care access, equity and outcomes for all individuals, particularly those in underserved and rural areas.

ABOUT THE ISSUE BRIEF

This brief is based on work done by Wyatt J. Beckman, M.P.H., C.H.E.S., Valentina Blanchard, M.P.H., L.M.S.W., and Linda J. Sheppard, J.D. Support for this brief was provided by the United Methodist Health Ministry Fund, a statewide health foundation working to improve the health of Kansans since 1986 through funding innovative ideas and sparking conversations in the health community. Learn more at healthfund.org.
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