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Community Health EMS Definitions and Terms

Community Health EMS is an emerging field in health care in which EMTs and Paramedics practice in expanded roles to connect to underutilized resources with underserved populations or gaps in care in a community.

Community Paramedicine - Mobile Integrated Health - Community Health EMS

All too often, people researching this subject come upon several terms which at times are used interchangeably and other times appear to be something different. Following are generally accepted definitions of these terms:

Community Paramedicine (CP) is the provision of healthcare using patient-centered, mobile EMS resources in the out-of-hospital environment. CP is one or more preventive or primary care services provided by EMS agencies and providers who are administratively or clinically integrated with other healthcare entities.

This is the most widely used term to describe this subject. However, many people seeing this term assume that community paramedicine is only about the use of paramedics in urban communities (and excludes other levels of EMS providers such as Emergency Medical Technicians and Advanced EMTs). Outside of the U.S., all levels of providers are typically called 'paramedics' and there is little confusion about the inclusive use of community paramedicine.

Mobile Integrated Healthcare (MIH) is the provision of community health by a wide array of healthcare entities and practitioners that are administratively or clinically integrated. EMS agencies and providers who are integrated with a MIH healthcare community and may work with community health workers, public health nurses, home health, hospice and other healthcare providers.

Community Health EMS (CHEMS) is not as widely used but it's not uncommon in rural states seeking to broaden public thinking about CP to incorporate the use of all levels of EMS providers (EMT, Advanced EMT, paramedic). Other variations that show up in state statutes include:

- community integrated EMS
- community EMS
- community assistance referral and education (CARES) program
- community-based prevention services

Senate Bill 104

The core elements of SB104 related to implementation of CHEMS/CP lies in three parts of a bundle of EMS statutes:

Montana Code Annotated
TITLE 50. HEALTH AND SAFETY
CHAPTER 6. EMERGENCY MEDICAL SERVICES
Part 1. Development of Program
Part 2. Emergency Medical Technicians
Part 3. Ambulance Service Licensing
Part 4. State Trauma Care System
Part 5. Automated External Defibrillator Programs

SB104 was introduced because current statutes were adopted decades ago used language that seem to limit the EMT/paramedic practice to "emergency medical care of the sick and injured at the scene and during transport to a health care facility...during the first critical minutes immediately after an accident or the onset of an emergent condition". Furthermore, statues related to ambulance services describe their purpose as "prehospital or interfacility emergency medical transportation or treatment services".

Legal interpretations of these statutes ranged from 'community-based healthcare by EMS is illegal' to 'non-emergency care is not described in statute and cannot be regulated'. The confusion was the impetus for the introduction of SB104.

In Part 1 of MCA 50-6, SB104.02 proposed edits starting on page 14 to change 'emergency medical services program' to a more contemporary 'emergency care system' term. In addition to DPHHS's role supporting and regulating ambulance services, it is engaged with development of trauma, cardiac and pediatric systems as well as injury prevention programs related to these systems. Amended language also adds "community-based prehospital medical care" to the traditional emergency care role of EMS.

> ***Section 11.*** *Section 50-6-101, MCA, is amended to read:*
> ***"50-6-101. Legislative purpose.*** *The public welfare requires the providing of assistance and encouragement for the development of a comprehensive emergency ~~medical services program~~ care system for Montanans who each year are dying and suffering permanent disabilities needlessly because of inadequate emergency medical services. The repeated loss of persons who die unnecessarily because necessary life-support personnel and equipment are not available to victims of accidents and sudden illness is a tragedy that can and must be eliminated. The development of an emergency ~~medical services program~~ care system is in the interest of the social well-being and health and safety of the state and all its people who require emergency and community-based prehospital medical care."*

Section 12. *Section 50-6-102, MCA, is amended to read:*
"50-6-102. Department to establish and administer program. *The department of public health and human services shall establish and administer an emergency ~~medical services program~~ care system."*

Section 13. *Section 50-6-103, MCA, is amended to read:*
"50-6-103. Powers of department. *(1) The department of public health and human services is authorized to confer and cooperate with any other persons, organizations, and governmental agencies that have an interest in the emergency medical services problems and needs care system.*
(2) The department is authorized to accept, receive, expend, and administer any funds that are now available or that may be donated, granted, or appropriated to the department.
(3) The department may, after consultation with the trauma care committee, the Montana committee on trauma of the American college of surgeons, the Montana hospital association, and the Montana medical association, adopt rules necessary to implement part 4 of this chapter.
(4) The department shall continually assess and, as needed, revise the functions and components that it regulates to improve the quality of emergency medical services and to ensure that the emergency care system adapts to the changing prehospital care needs of the citizens of Montana.
(5) The department shall collaborate with other components of the health care system to fully integrate the emergency care system into the overall health care system to identify, modify, and manage illness and injury"

Part 2 of MCA 50-6 provides the Board of Medical Examiners in the Department of Labor authority to license and regulate 'Emergency Care Providers' (Emergency Medical Responders, Emergency Medical Technicians, Advanced EMTs, and Paramedics). On page 16 of SB104.02, proposed language adds "community-based health care" to the traditional role of ECPs providing "care of the sick and injured at the scene and during transport…"

Section 15. *Section 50-6-201, MCA, is amended to read:*
"50-6-201. Legislative findings -- duty of board. *(1) The legislature finds and declares that ~~prompt and efficient emergency medical care of the sick and injured at the scene and during transport to a health care facility is an important ingredient necessary for reduction of the mortality and morbidity rate during the first critical minutes immediately after an accident or the onset of an emergent condition and that~~ a program for emergency ~~medical technicians~~ care providers is required in order to provide the safest and most efficient delivery of emergency care.*
(2) The legislature further finds that prompt and efficient emergency medical care of the sick and injured at the scene and during transport to a health care facility is important in reducing the mortality and morbidity rate during the first critical minutes immediately after an accident or the onset of an emergent condition.
(3) The legislature further finds that community-based health care integrated into the overall health care system can prevent illness and injury and can help fill gaps in the

state's health care system, particularly in rural communities with limited health care services and providers.
(4) The board has a duty to:
(A) LICENSE COMPETENT EMERGENCY CARE PROVIDERS TO PROVIDE PREHOSPITAL CARE AND OTHER SERVICES AS PART OF AN EMERGENCY CARE SYSTEM; AND
(B) ensure that emergency ~~medical technicians~~ care providers provide proper treatment to patients in their care."

Part 3 of the EMS acts includes authority for DPHHS to license and regulate EMS services (Non-Transporting Units, Ground and Air Ambulance Services). On page 19 of SB104.02, a new definition for "emergency care system" is proposed to support the addition of the term in Part 1. Edits also add community-based health care to the EMS service role.

Section 20. *Section 50-6-302, MCA, is amended to read:*
"50-6-302. Definitions. *As used in this part, unless the context requires otherwise, the following definitions apply:*
...
(5) "Emergency care system" means an organized system of emergency and prehospital medical care including prevention and community-based care of injury and illness, recognition of an emergency, provision of prehospital care, and integration of care in a hospital or other appropriate health care setting.
(6) "Emergency medical service" means a prehospital or interfacility emergency medical transportation or treatment service provided by an ambulance or nontransporting medical unit that is licensed by the department to provide:
(a) prehospital or interfacility emergency medical transportation or treatment services; or
(b) community-based health care services as part of an emergency care system that is integrated into the overall health care system.

The remaining 22 pages of SB104.02 are simply 'cleanup' edits and have nothing to do with CHEMS - primarily changing the generic term for all levels of EMT and paramedics from 'emergency medical technician' to 'emergency care provider'. Questions about these changes were at times a distraction from the CHEMS concept.

The introduction of the Veteran's CP concept was much more of a distraction as it appeared to be 'CP-like'. CHEMS/CP describes the utilization of EMS providers performing in an expanded role, but within their scope of practice. The Veteran's CP concept described numerous elements of education and practice that were beyond the normal ECP scope of practice and was not a comparable program at all.

What have other states done?
Statutory changes and CHEMS/CP Initiatives

In a survey from a few years ago, twenty-six states reported that their statutes either allowed CHEMS/CP or did not explicitly prohibit it. Two states (California and New York) had statutes that prohibited CHEMS/CP (both have since enacted enabling legislation). Colorado and Virginia established that EMS agencies would have to hold home health care licenses to implement CP (Colorado has recently updated their statutes to reconcile this).

Most states implementing CP programs are focusing on the use of paramedic providers and EMS services in more urban environments. The use of other levels of EMS providers in rural communities is not as common. Some rural examples of CHEMS/CP implementation include:

North Dakota – passed legislation in 2013 allowing pilot CP programs (paramedic based). With further legislative and rules changes, they began implementing use of EMTs and Advanced EMTs through a community health worker model. A Fargo pilot program focused on 'high-volume' users. Just three patients resulted in nearly a million dollars in ambulance bills. Keeping these people from calling 9-1-1 until they really need it saves hundreds of thousands of dollars in operational costs and lost man-hours.

Alaska Community Health Aide Program – The original model for CP, selected Alaska natives in remote communities were trained to distribute antibiotics to combat a tuberculosis epidemic back in the 1950's. It became a federally funded program in 1968 and today over 550 Community Health Aides/Community Health Practitioners are employed by 27 tribal health organizations in 178 rural/frontier communities. CHA/Ps are the patients' first contact within the network of health professionals in the Alaska Tribal Health System.

Eagle County, CO Community Paramedic program – Partnering with public health, they provide physician ordered non-acute home care and assistance with immunizations and screenings in rural areas where it is difficult for these services to be accessed. After 18 months of implementing the program, a net total of $288,028 in healthcare costs was saved.

Abbeville County, South Carolina – implemented reduction of non-emergent visits to the emergency department as well as inpatient stays through provision of in-home preventive care to patients. Emergency room visits were decreased by 58.7% and inpatient stays by 60%. Many patients previously needing consistent services now only need occasional check-ups.

Minnesota Community Paramedic Program – The pilot of this program was funded by the Minnesota Department of Public Health and Office of Rural Health. The first course consisted of hand-picked, experienced paramedics interested in providing an expanded role in their communities. As part of their education, each community paramedic conducted a community analysis to determine gaps in health care. These paramedics then molded their practice to needs ranging from staffing of mobile clinics for Native American populations, free clinics for communities, 'chase car' enhancement of local EMS response, and critical access hospital staffing.

Community Health / Community Paramedicine Implementation
Montana Opportunities

CHEMS/CP providers and EMS services help fill gaps in local healthcare by using existing providers in expanded roles. By utilizing EMS providers in an expanded role, CHEMS/CP increases patient access to primary and preventative care, provides wellness interventions, decreases emergency department utilization, saves healthcare dollars and improves patient outcomes.

Studies show that 10-40% (or more) of ambulance service responses are for non-emergent events. Many times, patients who lack access to primary care utilize EMS to access emergency departments for routine health care services. These patients could be more appropriately cared for in primary care offices or alternate locations.

The needs of each community may differ - so do the strategies that CHEMS/CP programs employ:

- Post discharge programs help avoid unnecessary EMS transports, ED visits and hospital readmissions. Patients may have questions about discharge instructions; need assistance with obtaining prescriptions; and have concerns about their recovery. CHEMS/CP visits decrease the number of 9-1-1 responses from people who access EMS for an ED visit for these issues.
- "Frequent user program" – Any EMS service knows the patient that is transported over and over – many times for non-emergency purposes. CHEMS/CP visits timed to visit these patients on a regular basis to alleviate their concerns can dramatically reduce 9-1-1 responses.
- Primary care interventions – Many activities that require a patient to schedule an office visit can also be implemented by trained providers in a home visit. CHEMS/CP providers afford efficiencies by acting as an extension to primary care provider's practices.
- Chronic disease monitoring and education – Particularly with unstable or difficult to manage conditions (such as diabetes, asthma and cardiac conditions), regular visits by CHEMS/CP providers can help patients stay healthier and prevent frequent emergency interventions necessitating ambulance transports and ED visits.
- Integration with home health, hospice and other programs – Particularly in rural communities with limited resources, CHEM/CP providers can act as an extension to the nurses and other primary providers and enhance their capabilities and programs.
- Public health programs and interventions – CHEMS/CP providers can also partner with public health providers and be engaged in conducting home safety, fall prevention, patient education and other public health programs to prevent injuries and illness.
- Mental health – In collaboration with other mental health services (which are limited in many communities), CHEMS/CP providers can partner with mental health providers to monitor patient conditions on a more frequent basis and participate in field assessments that may expedite transport to facilities and resources for appropriate than an emergency room.
- Patient navigation / access to alternative care – CHEMS/CP providers can participate in being the bridge between a patient's needs and health care resources (instead of the ED) in the community.

Community Health / Community Paramedicine Implementation Challenges

Legislation / Regulation

CHEMS/CP emphasizes the role of EMS providing primary and preventative care in the patient's home. It is already an environment and role in which EMS providers and EMS services already practice. Much of the infrastructure and regulation is already in place to allow community paramedicine.

Passing legislation such as SB104 does not automatically mean that CHEMS/CP programs will be implemented immediately. The Board of Medical Examiners will need to develop education guidelines, protocols and credentialing for each level of provider. DPHHS will need to develop rules, tools and guidance for EMS services related to conducting community gap assessments, integrating with physicians, nurses and other health care providers, and to conducting performance improvement.

In order to approach a myriad of issues, DPHHS would engage stakeholders representing EMS, medical directors, nurses, hospitals and others on issues such education, medical oversight, funding and integration with other health programs.

Education / Credentialing

A community paramedic's education should prepare EMTs to meet identified community health needs and should address gaps revealed by a community assessment. As such, CP education should be standardized, but capable of being tailored for each community.

Several organizations studied community health education programs from places such as Alaska and Australia and have created a curriculum for community paramedics in the States. This group provides the curriculum to accredited colleges and universities and these institutions can then customize the curriculum for individualized programs. An abbreviated curriculum design for basic providers such Emergency Medical Technicians is soon to be released.

As with any education in Montana, the implementation of education as close to the provider who needs it will be a challenge. Innovations in delivery of education utilizing tele-video and distributive education strategies to minimize expense and travel will be essential.

Integration with Nursing and other Health Professions

Key recommendations of Institute of Medicine reports are that EMS needs to be more integrated with the other elements of the health care system. Community paramedicine represents an opportunity to affect such integration.

Approached correctly, the introduction of community paramedicine should be viewed as an opportunity not a challenge or a threat to other providers. Particularly in rural communities where health resources are limited, extending the role of the CP into different settings and partnering with public health should be viewed as a benefit to the patient. If communities continue to understand that CHEMS/CP providers have a unique education and background and that nursing also has a unique education and background – and that each can complement rather that compete with each other – potential conflicts should be negligible.

Currently, CP programs have found ways to foster such partnerships and have not created disagreements and conflict. Montana will need to proactively foster discussions, provide education, and develop partnerships with professional groups and advocates to best ensure the success of a CHEMS/CP programs.

Funding / Reimbursement

Community paramedicine is not without data showing cost savings. After five years, a Nova Scotia program demonstrated a 40% reduction in emergency room visits and a 28% reduction in clinic visits. A U.S. program that focused on preventing readmissions of frequent flyers quoted a 64% reduction in 9-1-1 visits and $1 million savings in health care costs.

Currently, EMS is only reimbursed for transport of a patient to an emergency room. Medicare has funded numerous CP programs across the county and the case has been made to justify reimbursement for CHEMS/CP visits to prevent transports and transport to alternate destinations. While reimbursement reform on the federal side is likely, change is slow.

In the absence of such federal action, numerous other funding and reimbursement strategies are being realized. How these might be applied in Montana, especially in rural communities, will be challenge – but many show promise:

- Some insurance companies are reimbursing for CP services as they recognize how a program can keep their customers healthier and happier at a cost savings to the company.
- In several states, Medicaid is reimbursing for CHEMS/CP.
- Accountable Care Organizations and Medical Homes are including EMS in their team approach to providing healthcare and EMS is being paid for their contribution.
- CMS penalizes hospitals for readmits of some patients within 30 days. Some CHEMS/CP programs are being funded from the cost savings of preventing these readmits over time.
- Some EMS services accept the costs of CHEMS/CP as part of their business and the resulting decrease in non-emergency transports that are not reimbursable as cost and manpower savings.
- Physicians have adapted their practices to include CHEMS/CP as part of their office operations and have recognized the savings in funding CHEMS/CP to monitor their patients and schedule office visits more appropriately (preventing ED visits).