

# Community Paramedic Program Handbook

Kentucky Board of Emergency Medical  
Services



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## **Executive Summary**

*Eighty percent of America’s landscape is rural area with one fourth of the population living in these areas. Kentucky is no exception. Many people living in rural areas are aging, impoverished, and lacking healthcare services due to vast distances they must travel to medical facilities. Ensuring that all citizens are getting access to primary and preventative care is a challenge. Due to the aging “Baby Boomer” generation, the number of people with healthcare needs is rising. Oftentimes, routine healthcare services, immunizations, and follow-up services are lacking, resulting in what otherwise would have been avoidable acute healthcare needs, including hospitalizations. A large amount of ambulance transports in Kentucky are non-emergent and non-acute. It is commonly known among emergency medical services (EMS) providers that many individuals are utilizing medical transportation services due to a lack of primary care access. Many populations in the state lack adequate healthcare facilities and providers, especially in rural areas. Readmissions to hospitals are common due to patients not following care plans or following up with primary care physicians.*

*Community Paramedicine is a new healthcare model for a concept that has been in practice well before the Emergency Medical Services (EMS) Development Act in 1973. Traditionally, the primary focus of EMS has been to assess and treat the acute medical and trauma patient while transporting to an emergency department. Through the evolution of EMS, roles have expanded to include inter-facility transport of the non-acute patient, blood pressure checks at local health fairs, transfers to and from routine physician’s appointments, as well as providing standby care at community and sporting events. The goal of Community Paramedicine is to fill gaps in healthcare services by identifying the particular needs of a community and developing ways to meet those needs. The means to fulfilling these needs may vary in different areas, as the community paramedic’s roles are based on community needs assessments conducted for each community. The intent of this report is to determine the need to further discuss the feasibility and desirability of finding collaborative approaches among a wide range of healthcare provider agencies and professions to potentially make Community Paramedicine in Kentucky a reality.”*

*Michael E. Poynter,*

*Executive Director*

*Kentucky Board of Emergency Medical Services*

### ***Kentucky's Move in the Direction of Community Paramedicine***

*The Kentucky Board of Emergency Medical Services (KBEMS) began the process of evaluating the feasibility of implementing a Community Paramedicine program for Kentucky in 2013. Prior to that date, the National Association of State Emergency Medical Officials (NASEMO) and National Organization of State Offices of Rural Health (NOSORH) encouraged state EMS Programs and State Offices of Rural Health to partner in exploring the Community Paramedicine concept. The intent was to relieve the potential healthcare provider shortage, particularly in rural areas, as well as prepare to meet the future demand on the healthcare system with the aging of the Baby Boomer Generation.*

### ***The Definition and Role of the Community Health Paramedic***

*The paramedic title is used internationally and in this case, is meant to maximize the current scope of practice of a Paramedic commonly in use in the United States today. The distinction in levels in other areas around the world and some parts of the US is oftentimes defined as; Primary Care Paramedic, Intermediate Care Paramedic, and Advanced Care Paramedic. The Community Paramedic certification will require additional training and education that would be determined by the Kentucky Board of Emergency Medical Services. Community Paramedicine does not change the EMS scope of practice for the healthcare provider. It is important to note that Community Paramedic is intended to be a part of the Mobile Integrated Healthcare System which would include other healthcare professions, such as nursing, physician assistants, social workers, and other allied health professionals. The Community Paramedic shall be required to work under a medical director's supervision and liability.*

*The working definition of Community Paramedic, is stated as: "...a state licensed EMS professional that has completed a formal standardized educational program through a KBEMS approved level 3 Training or Educational Institution and has demonstrated competence in the provision of health education, monitoring and services beyond the roles of traditional emergency care and transport and in conjunction with medical direction. The intent of mobile integrated healthcare is to address areas of need that were identified in community needs assessments. Mobile Integrated Healthcare Systems has been shown to reduce inappropriate utilization of EMS and Emergency Department services for non-emergent care.*

## **History of Community Paramedicine**

*The term “community Paramedicine” was first described in the U.S. in 2001, as a means of improving rural EMS and community healthcare; however, it is not a new concept in practice. Increasingly EMS personnel are caring for patients with non-emergent medical problems in their day-to-day role as emergency responder. For example, studies place the number of low-acuity transports (e.g., sprains or flu-like systems) at 10–40%. Thus, it is not surprising that the field is moving toward a more community- based approach. National organizations have written about this progression for years. In 1996, a National Highway Traffic Safety Administration report described an EMS of the future with the ability not only to provide acute care, but also identify health risks, provide follow-up care, treat chronic conditions and monitor community health.*

*The 2004 article, “Rural and Frontier EMS Agenda of the Future,” provided a vision of EMS personnel providing not only a rapid response, but also filling roles in prevention, evaluation, triage, and referral (McGinnis, National Health Association Press). In 2010, the Joint Committee on Rural Emergency Care (JCREC), which is comprised of members from the National Association of State Emergency Medical Services Officials (NASEMSO) and the National Organization of State Offices of Rural Health (NOSORH), issued a discussion paper which called the community Paramedicine model “One of the most progressive and historically-based evolutions available to community-based healthcare,” further praising its potential to decrease emergency department utilization, save healthcare dollars and improve patient outcomes.*

## **Background of Community Paramedicine Models**

*Community Paramedicine is not new to the United States. Similar programs have already been initiated in the US and around the World:*

- Alaska’s Community Health Aide Program, has been in practice in remote villages in Alaska since the 1950’s, when it was found to be an effective way for village workers to administer antibiotics to victims of the tuberculosis epidemic. It continued to further meet the healthcare needs of Alaskan Natives and became a federally funded program in 1968. 178 rural villages in Alaska are utilizing Community Paramedics.*
- In Texas, Med Star’s TX Alternative Destination/Alternative Transport Program is a cooperative of Med Star, the emergency physician’s board, and public health. The three primary purposes for the Med Star Community*

Health paramedic are; (1) Reduce the probability of providing acute emergency medical care for at risk patients and the medically underserved, thereby reducing unnecessary health care expenditures. (2) Increase the outreach activity and public education components of EMS providers and (3) Generation of potential revenue.

<http://www.medstar911.org/Websites/medstar911/Files/Content/1089414/MedStar%20CHP%20detail.pdf>

<http://www.medstar911.org/community-health-program>

- Wake County EMS in Raleigh, NC's program chooses the most experienced providers and utilizes them by serving dual functions; one end that is human services in nature and the other end that deals with high acuity calls such as cardiac arrest. "Studies show that diabetics, high blood pressure patients with congestive heart failure, those with increased risk of falls (such as people over 65 years of age), some substance abusers, and children with asthma may all significantly benefit by home visits from medical care providers like our Advanced Practice Paramedics."

<http://www.wakegov.com/ems/staff/app.htm>

- In Minnesota, the Community Paramedic pilot program was funded by the Minnesota Department of Public Health and Office of Rural Health. The first providers were specifically selected from experienced paramedics. As part of their education, each provider conducted a community analysis to define gaps in healthcare, and then designed each service to fit the needs of that specific community. More information can be found at

<http://minnesota.publicradio.org/collections/special/columns/ground-level/archive/2011/04/paramedics-take-on-expanded-healthcare-role-in-rural-minnesota.shtml>

- In San Francisco, they deal largely with the homeless population and repeat calls. Their goal is to connect these people with the resources that will ultimately reduce their need to call EMS for transport to emergency departments.

- In 2005, a community health assessment discovered that 46 percent of the people of the Western Eagle County Ambulance District in Eagle, Colorado were uninsured. 38 percent showed difficulty in accessing medical care, and 80 percent of all emergency department visits were for non-emergent, non-acute issues. The community paramedics in this area are sent by physicians to the patient's homes to focus on preventative care, vaccinations, fall prevention, and blood glucose monitoring. In addition, community paramedics assist individuals in finding the appropriate social service needs and helping to assure a safe home environment with heat, appropriate food, and access to a primary care physician.

<http://wecadems.com/cp.html>

- Guanajuato, Mexico, developed a program independently in the 1990's that evolved to mirror the Alaskan Community Health Aide Program

## **Recommendations**

*Changes will need to be reviewed to pre-hospital statutes, protocols, rules and regulations before the program could be implemented in Kentucky.*

- *Statute would need to be modified to allow the EMS board the authority to oversee the new certification.*
- *Determine in statutes stating where the Community Paramedicine can practice. Currently paramedics can only practice in a clinical setting or pre-hospital as a member of a service. This needs to be clarified for all levels.*
- *The skill sets of Community Paramedicine will need to be clearly defined.*
- *Working definition as written does not include other healthcare professions. This will need to be addressed.*
- *Examine the curriculum and further define how it is to be followed and what the minimum core content should include with the expectation that additional modules will be completed to fit the needs of the local communities' specific needs.*
- *The EMS Program and/or a select group is recommended to develop a program to educate the public, hospitals, and healthcare providers about Community Paramedicine and its potential role in providing patient care outside of an emergency setting.*
- *Research needs to be looked at to determine the potential financial impact on rural physicians.*
- *Avenues of funding will need to be looked at.*

## **Our Goals**

*The goals of the Community Paramedic Program are twofold: to improve health outcomes among medically vulnerable populations; and to save healthcare dollars by preventing unnecessary ambulance transports, emergency department visits, and hospital readmissions. The Community Paramedic model has two components:*

- 1) *Patient care services, directed by a medical director, and*
- 2) *Community-based prevention/wellness and injury/illness.*

## **Patient Care Services**

*As a way to increase availability and continuity of health care for vulnerable populations, specially-trained paramedics provide specific patient care services working through medical direction. The services are within the*

*paramedic's legal scope of practice, and the paramedics have been educated and evaluated on their ability to provide such care.*

*The Community Paramedic takes a patient history, assesses the chief complaint, and then utilizes protocols with the treating provider on next steps. The paramedic may also conduct a home safety check and assess the need for referral to an appropriate community resource. A patient care report is developed and sent to the ordering provider to be placed in the patient's chart. This type of care is perfect for many vulnerable populations including:*

*The chronically ill who have a challenging time getting to their medical provider's office and frequently cancel appointments.*

*Patients recently hospitalized that would benefit from monitoring sessions to prevent complications.*

*Patients in need of social supports who frequently call 9-1-1.*

### **Community-Based Prevention Services**

*Community Paramedics may assist the local medical community-based services such as, but not limited to, immunizations, disease investigations, blood draws at health fairs, mass vaccination clinics, or other identified community health needs.*

### **Some roles may include**

- *Encourage responsibility of patient to manage his or her care and treatment*
- *Educate patient in medication administration to self and in compliance with physician recommendations*
- *Preventing falls and injuries by completing assessments in the homes and identifying risks*
- *Provide immunizations*
- *Work with a healthcare team to follow a care plan for the individual*
- *Monitor blood pressures and blood glucose levels*
- *Provide assistance in locating appropriate community based resources*
- *Treat acute healthcare issues and refer follow-up care*
- *Assist with mobility issues*
- *Wound care*
- *Patient education on medication side effects*

## **Value**

*According to the American Academy of Family Physicians (AAFP) a health system that focuses on primary care is more effective, more efficient, and more equitable among patient populations. These benefits are demonstrated by reduced mortality rates, less frequent use of ERs and hospitals, better preventive care, higher patient satisfaction, and a reduction in health disparities. In communities all across America, provider shortages are reducing access to this basic level of care. In fact, the AAFP reports that the number of medical school students entering primary care has dropped 51.8 percent since 1997. Demand for primary care physicians is only going to increase with the 2010 passage of health care reform that will vastly extend insurance coverage.*

*Additionally, one quarter of the U.S. population lives in rural and remote regions, and only 10 percent of the country's physicians practice in these areas. Compounding the problem are widespread hospital and clinic closures, an aging population, increasing cultural diversity, and the fact that rural residents are often economically disadvantaged and less healthy than their metropolitan counterparts. It makes sense to tap into EMS personnel that already live and work in these communities, in order to augment services and extend health care access.*

## **Curriculum**

*The development of the current iteration of the Community Paramedicine Curriculum addressed in this report began in 2007. The development of the Curriculum was made possible through collaborative efforts of representatives from Creighton University, Dalhousie University in Nova Scotia, Mayo Clinic in Minnesota, Offutt Air force Base, the North Central EMS Institute, and State Offices of Rural Health in Minnesota and Nebraska. This curriculum has been distributed to 42 universities, including the U.S., Australia, Great Britain, Israel, and Canada. The standardized curriculum design is modular based and can be customized for individualized certification or degree programs. There is a core content that the provider must take, with the remaining modules as options to fit in the scope of the community paramedic and the needs of the community. The curriculum offers education in community assessment, access and pathway coordination, access to mental*

*health services, preventative care, chronic disease maintenance management, wellness care, and preventive and maintenance dental care.*

## **Special Reports**

**Dr. Bill Raynovich** offered a summary of findings from a 2005 evaluation report of the Red River Project in New Mexico:

*The Red River Project began in 1995 and ended in 2000. It was considered to be one of the most progressive and successful expanded practice pilot projects at the time. A comprehensive evaluation that was funded by New Mexico Health and Human Services and approved by the University's Institutional Review Board was conducted by a research team from the University of New Mexico in 2000. The study evaluated patient care, community services, attitudes of members of the local healthcare community, clinical and administrative practices, and regulatory compliance. A number of positive achievements were noted by the researchers. Several significant negative findings reported by the research team resulted in terminating the project, however.*

*Positive findings in the evaluation of the Red River Expanded EMS Project included overwhelming community satisfaction with not even one negative comment or complaint registered by any resident of the community, care provided to hundreds of patients with no reported patient care complaints, lawsuits, or complications, and overwhelming support by area physicians, nurses and allied healthcare services providers.*

*Negative findings of the study included underreporting of activities (masked or hidden services provided by untrained providers), standards of care issues per an audit of patient care records (e.g., lack of tetanus documentation or compliance with standards and less than ideal clinical procedures), non-compliance with prescribing standards (e.g., antibiotics dispensed in a single dose with 90% of patients having no follow up), no continuing education standards, activities or documentation, and inadequate medical oversight and coordination of services with the area healthcare providers. The most important finding was that the program had become competitive with local healthcare providers rather than a gap filling service, as was originally intended.*

*The main recommendation of the research findings were that expanded EMS services could operate effectively to fill gaps in essential healthcare services but that close medical supervision and support and coordination with existing healthcare provider services was essential for long term success.*

*Some mathematical statistics on the possible financial outcomes of implementing a Community Paramedicine program:*

- *Reduce or eliminate a one day length of stay observation for six patients per week for one month:*

*One Day x \$5,217 bed cost x 6 patients x 4 weeks = \$125,217*

- *Reduce clinic costs for minor follow up procedures of ten patients per week for one month:*

*Ten patients x \$60.00 clinic cost x 4 weeks=\$2,400*

- *Reduce the cost of ambulance transport to a hospital for routine follow-up of eight patients a week for one month:*

*8 patients x \$415 ambulance cost x 4 weeks = \$13,280*

- *Prevent one in home fall related injury per month:*

*Four day length of stay x \$5,217 + \$5,000 rehab and home support cost per case + clinic fee \$560.00 + ambulance fee \$26,343*

*The potential downstream costs savings to the healthcare system per month would equate to \$167,240.00.*

### **Discussion:**

*Possible benefits and pitfalls to implementing a Community Paramedicine program in Kentucky:*

### **Negatives**

- *Perceived decrease in quality of care in order to cut costs.*
- *Could be perceived as a possible increase in workload for EMS providers.*
- *Would there be additional visits to the ED later due to complications from the original complaint?*
- *How will the program be funded?*
- *Concerns that Community Paramedicine would compete with other healthcare organizations already in place.*
- *Constancy is needed in the message of how Community Paramedicine can benefit Kentucky.*
- *Too many misconceptions in the public and healthcare field about Community Paramedicine; Better Education about the program needs to be implemented to provide awareness and clarity for the public and healthcare community.*
- *Possible lack of quality medical direction and supervision.*

### **Positives**

- *The team approach of working with a multi-disciplinary healthcare field.*

- *The ability to fill in gaps in the community.*
- *EMS may be better informed on individual patient care and ability to tap into the patient's needs.*
- *Improve field screening capabilities-referring patients that don't need emergency care to the appropriate facility.*
- *May help retention of EMS personnel due to overwork and lack of burnout.*
- *Greater opportunity for EMS to become an integrated part of the healthcare continuum*
- *Decrease hospital readmissions.*
- *Decrease emergency department visit for non-acute events.*
- *Decrease unnecessary costs.*
- *Clinical gaps in services will be filled.*
- *Economic efficiencies in the overall healthcare system.*
- *Patient safety would be assured by better regulatory oversight.*
- *Additional career opportunities will be provided.*
- *Quality assurance will be monitored by a physician medical director.*
- *Improved quality of life for the patient.*
- *Community Paramedicine offers a holistic approach to care in the field.*
- *Continuity of patients' electronic care records can be maintained in conjunction with the healthcare team.*
- *Care is provided in the home and offers alternatives to ED wait times.*
- *Treat and refer/release will result in cost savings to patient.*
- *A new level of professionalism to EMS providers would be available.*
- *Behavioral health patients would have assistance after hours.*
- *Offer mental health support to individuals that would otherwise call 911.*
- *EMS could get paid for services that they already are doing but not getting paid for due to non-transport.*
- *Community Paramedicine would involve mapping of the community and discovering needs that would otherwise go unnoticed.*

## **Resources**

*Today, various forms of community Paramedicine programs are operating both nationally and internationally. According to the Joint Committee on Rural Emergency Care, the expanded role of EMS personnel has already occurred on a wide scale in countries such as England, Australia and Canada. In the United States, paramedics with community-based functions are being used locally in states like Colorado, Minnesota, Texas, Nebraska,*

*California, Pennsylvania and North Carolina. However, program services and operations vary. Community Paramedic programs are born out of necessity and as such, are based on specific community needs. The Joint Committee aptly states, "If you have seen one community paramedic program, you've seen one community paramedic program."*

*For example, the state of Nebraska has used a "top-down" approach to develop a community Paramedicine system. The effort was led by the state's EMS Office and Office of Rural Health, which jointly advocated for state legislation as a means to provide standards for the development of local programs. Minnesota used a "middle-out" approach by developing a training program thorough a collaboration of partners, which was then offered to any interested paramedic within the state. Colorado used a "bottom-up" approach that began at the grass-roots level through a partnership between a local ambulance service and public health department, and in cooperation with the state EMS Office. The intent was to pilot this local program with the goal of replication. These programs, along with additional background on the community Paramedicine field, are described in the Joint Committee on Rural Emergency Care article, "State Perspectives: Discussion Paper on Development of Community Paramedic Programs" (2010), which is available online at:*

*<http://www.nasemso.org/Projects/RuralEMS/documents/CPDiscussionPaper.pdf>*

*Work is being conducted on a national level too. The Community Health Care Emergency Cooperative, which is representative of local programs and national organizations, has developed a standard curriculum for college credit that includes a 12-week classroom and Internet course, hands on lab sessions, and clinical rotations with oversight by medical providers. The aim of curriculum is to be portable so local programs can use their own academic institutions and community medical providers. Information can be found online at:*

*[www.communityparamedic.org/Colleges.aspx](http://www.communityparamedic.org/Colleges.aspx).*

*Another good resource is the International Roundtable on Community Paramedicine, which provides an up-to-date, informational website and holds annual conferences on advances in the field:*

*[www.ircp.org](http://www.ircp.org).*

# **Program Development**

*The following is an overview of recommended steps for this “bottom- up” approach. Steps can be modified to fit local needs and aren’t necessarily linear in their time frame, in fact some may need to occur simultaneously.*

## **Plan to Plan**

*The first step in developing a Community Paramedic program is to learn all you can about this up- and-coming field, the various programs in operation today, and the scope of training required for this new type of paramedic. Doing your homework upfront will allow you to begin formulating the vision and scope of your program, so that you may effectively propose the idea to stakeholders. This handbook will provide you with most of the background you will need to begin. Appendix A provides a list of resources for additional guidance during your information gathering process. Developing a Community Paramedic program requires the ongoing management of multiple logistics requiring significant legwork. To help plan and track all of the tasks, develop a work plan and fill it in to the best of your ability now, and update it as you go. A sample work plan has been attached as Appendix B.*

## **Assess Program Feasibility and Engage Key Partners**

*You should determine early in the process whether such a program is even feasible in your area, given state EMS laws and the level of commitment needed internally, from local medical providers, and from a community college or university. The following section provides a list of initial contacts and commitments you will need.*

### **Program Feasibility Checklist:**

- *Are there any state regulatory barriers that need to be dealt with first?*
- *Does internal buy-in exist among EMS Personnel, Medical Director and Board?*
- *Are local physician practices willing to participate? Train paramedics?*
- *Is a local college, university, or EMS Level III Training Institute available to teach the Community Paramedic course?*

### **Ambulance Service**

*First, propose the idea internally. You will need commitments from everyone within the organization including the agency director, EMS personnel, board members and medical director. The paramedics will be required to participate in a fairly rigorous training program, both up front and in an ongoing manner. Make sure personnel are willing to take on this additional role. Obtain assurances from the board of directors that: 1) they will support the organization in focusing on program development, which could take 1-2 years to operationalize; and 2) they understand that internal resources, including funding, may need to be shifted toward program support. Finally, gain a commitment from the medical director that they will provide the medical oversight, including the development of quality assurance mechanisms, advising the clinical training process, and evaluating the competency of the Community Paramedic's skills.*

### **Medical Providers**

*Next, approach medical providers to make sure there is enough physician buy-in to make the program worth developing. The participation of primary care physicians is key to the success of the grass roots model since they have a major role in training the Community Paramedics during clinical rotations, and providing the orders to use them. Physician commitment will be one of the greatest determinants of program feasibility. If your program wishes to also make clinical assistance available to the local public health department or assist them with prevention activities, they should also be engaged at this step. Note that not all public health departments offer client-level medical services, but they are a good partner nonetheless, and may be able to help you recruit physicians for the program. Eventually, you will want to formalize relationships with these entities through a legal agreement such as a memorandum of understanding (MOU). (See Appendix C for an example.*

## **College or University**

*In order to utilize the Community Health Care Emergency Cooperative's Community Paramedic Curriculum, training must occur thorough a community college, university, or EMS Level III Training Center (TEI) willing to teach the curriculum, coordinate the clinical rotations, and provide academic credit. You should gain commitment from an academic institution early in the process, to make sure that training is available for the program. The director of the EMS division at the institution will be the best contact and should also be the person to request the curriculum from the Cooperative.*

*The college or university will need to employ and pay for the faculty member that will be teaching the course. Ideally, the course instructor will have an understanding of the EMS system, the roles of the various levels of providers (EMT, paramedic, public health nurse, social worker, etc.) plus, experience working within the health care system, and familiarity with community resources. Because the course is set up to have online sessions, the institution should also have a system that can accommodate this, like an online "Blackboard." Note that a legal agreement (e.g., MOU) with the institution is critical to have in place before training begins.*

## **Determine How to Provide Medical Direction**

*The program's Medical Director will have specific duties related to the Community Paramedic program. For example, they will evaluate the Community Paramedics after completion of training, annually, and as needed. A sample evaluation tool is provided within the Community Paramedic Curriculum. They will also perform chart reviews and provide feedback to the paramedics. This process should be rigorous at first, by potentially looking at all clients during the program's pilot phase (for example, the first 50 patients), and then determining the criteria for regular reviews after that. During chart reviews, the medical director can evaluate whether the CPs are assessing the patients appropriately, documenting appropriately, communicating adequately with the ordering physician, making referrals, following policies and procedures, and meeting general patient and provider needs. Client satisfaction surveys are one tool that can help the Medical Director assess patient care on many levels. A sample tool is provided as Appendix D. Patient case studies performed with the paramedics for a high-risk type of visit will help to build judgment and continue the*

*learning process. The medical director may also be part of call down list if the ordering physician is not available when the home visit is conducted.*

*You might consider for a local primary care physician to share the medical oversight with the organization's medical director. Additionally, ordering physicians that are participating in the program are teaching and evaluate skill competencies during clinical rotations (All of these roles are clarified through a Memorandum of Understanding with each physician practice).*

### **Assess Community Health Needs**

*The Community Paramedic program will be better able to make the case for its existence, obtain resources, and have more of an impact on community health overall, if services are based on a needs assessment. A community needs assessment can determine:*

- The leading causes of preventable morbidity and mortality*
- Gaps in health care services*
- Demographics of the populations most impacted by the gaps*
- Characteristic of those who most frequently use the ambulance service*
- Most frequent conditions requiring hospital readmission*
- The greatest health care needs as seen by local medical providers*

*Your local public health agency has experience conducting health assessments and could be a good resource for this activity. The department regularly tracks community health outcomes such as death, injury, and disease rates, which could be used for program planning and evaluation. For example, areas with a high rate of senior falls may wish to add a safety check to Community Paramedic home visits. Patient databases at the hospital and ambulance services are two sources of queryable data. The ambulance service database can provide the medical description and demographics of patients that place frequent 9-1-1 calls. The hospital database may be able to provide a list of the conditions most frequently requiring hospital readmission that could be targeted for a CP visit. Finally, one-on-one medical provider interviews can provide qualitative information about how a CP program can best help them fill health care gaps and serve their most vulnerable patients*

## **Determine the Scope of the Program**

*During this phase, you will want to determine the types of services to be offered, personnel needs and program budget, based on the results of the community needs assessment, services provided in the Community Paramedic Curriculum, and the level of funding your agency either has or will be able to raise toward this program.*

## **Services**

*The first step is to determine whether your Community Paramedics will provide in-home patients visits and/or community-based services, as both require a different type of clinical training. Be sure that the services you are envisioning are within the legal scope of practice for your paramedics, based on state regulations. Eventually, the program's medical director will need to approve these. Common services include: assessment (vital signs, blood pressure, labs such as glucose levels, medication compliance), treatment (wound care, medication administration), prevention (immunizations, in-home fall prevention) and referral (medical and social services).*

## **Personnel**

*Each program will need to determine the number of Community Paramedics and their schedule, based on the needs assessment, frequency of ambulance calls, and population size. Community Paramedics can be scheduled based on a couple of different scenarios: 1) If the agency has enough EMS personnel, the Community Paramedic could be assigned discreet and prescheduled times to see clients when they are not designated as an emergency responder; 2) If the Community Paramedic has a dual role of emergency response, consider scheduling them on the second response team at pre-determined times to allow more prescheduled opportunities to see clients.*

*In terms of other types of personnel, the program will require programmatic and medical oversight, program coordination, scheduling, fundraising, and evaluating. Agency personnel or contractors may be used to fill these functions, and a single position may fill more than one function; for example, the program coordinator may also schedule patients. The following are examples of positions used within the program:*

- Medical Director

- Program Director
- Community Paramedic
- Quality Assurance Coordinator
- Program Coordinator
- Scheduler
- Evaluator
- Grant Writer

### **Budget and Fundraising Needs**

*Based on the services you plan to offer and the staffing patterns necessary to support them, develop a program budget and fundraising plan. Determining whether new personnel need to be hired will depend on the scope of the program and population of the service area. In some cases, it may be possible to shift in-house personnel. For intermittent functions like grant writing, a contractor may make the most sense dollar-wise. For the operational budget, the need for new items such as a daily means of transportation (non-ambulance vehicle) and primary care equipment will need to be determined. Tuition costs and training supplies will also need to be quantified for the Community Paramedic course provided by the local community college or university, if the agency will be the entity to pay for such training. Examples of potential line item budget expenses are provided as Figure 2.*

*After developing a budget, it may be necessary to create a fundraising plan with targets set by dollar amount and deadlines. A multi-year budget can inform fundraising targets for consecutive years. Sources of funding may include local, state and federal governments, foundation grants, and donations from community partners. In the future, it may be possible to bill Medicaid and Medicare.*

### **CP Program Tip**

*Some of the patients of the Community Paramedic program might be uncomfortable with an ambulance pulling up to their house for a home visit, because it causes unnecessary concern to neighbors. You might consider a sedan or an SUV.*

**Figure 2: Sample Budget Items**

<i>PERSONNEL</i>	<i>Program Director</i>
	<i>Community Paramedic(s)</i>
	<i>Quality Assurance Coordinator</i>
	<i>Program Coordinator/Scheduler</i>
<i>CONSULTANT/CONTRACTUAL</i>	<i>Medical Oversight (Licensed physician)</i>
	<i>Evaluation</i>
	<i>Grant Writing</i>
<i>EQUIPMENT</i>	<i>Otoscope (with camera to send to physician)</i>
	<i>Stethoscope (digital to send read-out to physician)</i>
	<i>Temporal thermometer</i>
	<i>Pulse oximetry</i>
	<i>Digital camera (to send pictures to physician, e.g. wounds, cellulitis, home safety risks)</i>
	<i>Portable adult and baby scales</i>
	<i>EKG/defibrillators</i>
<i>LAB SUPPLIES</i>	<i>Dressing changes</i>
	<i>Blood draw</i>
<i>TRAVEL</i>	<i>Non-emergency vehicle (lettering, lights, radio if new)</i>
	<i>Motor vehicle insurance/gas</i>
<i>INSURANCE</i>	<i>Additional malpractice insurance (Check with insurance company)</i>
<i>UNIFORMS</i>	<i>Community Paramedic uniforms</i>
<i>TRAINING</i>	<i>Tuition, text books and supplies</i>

## **Engage the Community**

*A community engagement process is a good way to assess the level of community support, build advocates for the program, identify community resources, and determine potential barriers. Strategically anticipate how you will use different entities and who needs to know about the program early, in order to support it. Begin the process by developing key messages for specific audiences and determining how to target them.*

### **CP Program Tip**

*Before approaching stakeholders, prepare the following materials:*

- Local community health assessment*
- Program vision*
- Fact sheet.*

*Prepare to make the argument that the Community Paramedic program is not meant to replace a primary care provider, public health nurse or home health agency, but rather is intended to be complimentary to the health care system in breaking down silos and filling gaps.*

*It is particularly important to build relationships with the public health department and social service agencies early in the process, as these types of organizations can assist with community needs assessment, client referrals, and are likely to become champions for the program. Whether your program provides community-based services or not, the local public health department can also play a supporting role by helping to conduct a community health assessment to determine the population's health status and gaps within the health care system. Since a Community Paramedic program can be a good strategy to fill gaps and promote public health values such as the Medical Home Model and reducing barriers to care, partnering can benefit both entities. The health department also probably has strong partnerships with key medical providers and help to get them on board. Additionally, the department likely has experts in the realm of program evaluation and can suggest different methodologies and assist with the CP Program's process.*

*Social service agencies offer programs that may benefit the Community Paramedic client. Because the Community Paramedics get a first-hand look at the client's home environment, they are in the perfect position to assess the types of referrals that may benefit the client such as Medicaid enrollment, mental health treatment, case management, and assistance with food and home utilities. Social service agencies will be integral in educating Community Paramedics during the training phase, about the types of community resources available and how to make referrals.*

*Buy-in is also beneficial from other medical providers like home health agencies and physician practices that are not participating in the CP program, so that they understand the niche of a Community Paramedic and so-called turf issues can be avoided. Other types of organizations that should be engaged include local governments, foundations, civic groups, the state's Office of Rural Health and other organizations that may provide funding, advocacy or other types of support.*

*Another way to engage stakeholders is to develop a community advisory committee that meets regularly. This group can be the eyes and ears of the community, providing insight, feedback and direction. The committee may have representation from medical providers, health and human service agencies, gatekeepers to underserved communities, consumers, elected officials and other community leaders.*

### **Develop Policies and Procedures**

*Because Community Paramedics are working in an expanded role and with new community partners, it will be important to develop policies and procedures that provide explicit boundaries around the program, clarifying what it is and what it is not. Community Paramedics should always follow the policies and procedures of their larger organization; however, P&Ps specific to the Community Paramedicine program will also need to be developed. In general, policies and procedures can:*

- *Outline the new role of the paramedic, stating that a paramedic is not to provide a service out of their scope of practice, and for which they have not been trained and evaluated.*
- *Define program services and operational policies such as response time.*
- *Outline the process for receiving requests to utilize Community Paramedics (Appendix G).  
(Providers should also be trained on the process.)*

- *Require the use of a Release of Information Form to protect patient confidentiality before a Community Paramedic begins care (Appendix H).*
- *Define the conditions under which the Community Paramedic may practice (within a specific service area, serving only providers with an MOU agreement in place, and in which settings--home or public health clinic).*
- *Provide the steps for when physician contact is needed during a visit and the ordering physician is not available (Appendix I).*
- *Define service-specific procedures such as:*
  - Home safety assessment (Appendix J)*
  - Evaluation for social support (Appendix K)*
  - Clinical services (wound care, medication compliance and reconciliation, etc.) (Appendix L)*

*The Community Paramedic Curriculum provides general guidelines to the paramedics about these types of policies during training. Individual organizations should develop their own policies, which can stand alone or be woven into procedures, job descriptions, legal agreements, etc.*

### ***Plan and Implement Training***

*There are three levels of training to prepare a paramedic to provide primary care through a physician's order: 1) a 12-week didactic college course, 2) hands-on lab sessions, and 3) clinical rotations. The curriculum used for the didactic course is available through the Community Health Care Emergency Cooperative (<http://communityparamedic.org/Colleges.aspx>) and must be taught through a college or university. The course consists of approximately six classroom presentations and 2-3 hours of weekly online sessions.*

*In order to pass the course, the individual paramedic must perform 32 hours of lab sessions and 100-150 hours of clinical time, depending on the specialties chosen. The clinical time is organized into two levels of training: The first focuses on the general clinic setting; the second concentrates in specialty areas, depending on the community's needs and program's scope. The college or university will coordinate the matching of the students with clinical sites; however, the Community Paramedic program should have already done the legwork in identifying and engaging local providers, to assure the clinical rotations are successful. Whenever possible, it will help to make the program successful if medical practices that plan to use Community Paramedic services provide training during the clinical rotation phase, so a level of trust can be established between the paramedic and ordering physician.*

*Before the clinical rotations can be arranged, the scope of Community Paramedic services will need to be determined, including the skills and procedures to be taught by the providers. Services need to be within the legal scope of practice and should be approved by the ambulance services medical director. Training and lab time should focus exclusively on the procedures that are going to be offered by the program. The Curriculum highlights primary care services already being performed by Community Paramedics. Local programs will need to make sure these fall within their state regulatory guidelines before including them in the scope of services.*

### **Develop an Evaluation Plan**

*Developing an evaluation plan during the planning process will provide many benefits to the program. First, it will assure that client databases are in place and collecting the right data, beginning with the first patient. Also, program evaluation at its basic level, will be required in any grant application for future funding, and an evaluation plan will make grant writing easier.*

*The first part of the evaluation plan should include a method for tracking patients in a queryable manner. If the organization already has a client database, such as an electronic medical record, this could be used; otherwise a spreadsheet program such as Excel or Access would also work if client information were entered after each visit. The database should track variables such as client demographics (age, gender, ethnicity, language, insurance status), services requested on an order, patient diagnosis, referring physician, time and date of call, chief complaint, referrals to other services by a Community Paramedic, and outcomes (e.g., ambulance transport, physician follow-up,*

*re-admission, no follow-up necessary). Collecting and analyzing this type of information will meet most types of grant requirements. This information can also inform programming in terms of staffing patterns, budget, training needs, gaps in service, and types of patients served. Descriptive statistics can then be used to illustrate the program such as:*

*Percentage of uninsured, Medicaid and Medicare patients*

*Percentage of Spanish-speaking patients*

*Age range of patients*

*Number of visits (total and average per patient)*

*Leading types of chief complaints (tracked by number of events)*

*Leading outcomes of visits (tracked by number of events)*

*Patient databases at the hospital or within the ambulance service can also illustrate program outcomes such as a change in the level of non-emergency transports and hospital readmission rates. The reduction in non-emergency transports can be targeted as a program goal by using the ambulance patient database to determine frequent callers to 9-1-1 for non-emergency transports, then coordinating with their physician to provide an intervention, which may include linking to social service agencies. Non-emergency transports can also be a baseline measure for the program, to determine CP program impact over time.*

*The hospital may have data that shows the most prevalent conditions likely to cause a readmission. The CP program, in cooperation with the discharging physician, can then target patients with these conditions. This can also be a baseline measure for the program to determine impact over time. If the program serves enough patients to impact county-level health outcomes, such as a reduction in injury or death rates, these indicators could be tracked and measured with the help of public health data sites.*

*Also, qualitative information can supplement the quantitative data by documenting case studies to illustrate outcomes and the value of the Community Paramedic program. In its most basic form, this is a narrative, which tells the story of particular CP cases. Case studies should meet certain criteria such as those where a negative outcome for the patient was either clearly or possibly avoided, due to the intervention of the Community Paramedic. Information can be elicited through an interview with the*

*Community Paramedic and/or ordering physician, to document the case. Case studies can include patient demographics, presenting problem, the CP intervention and resulting outcomes. Names should not be used to protect patient confidentiality.*

### **Begin Operations**

*Once legal agreements are in place with providers, and paramedics have been clinically trained and evaluated, the scheduler can begin accepting orders from the physician or requests from the public health department. An example of a Physician's Order Form is provided as Appendix M. Patients are served in one of two ways: 1) during a home visit through the medical providers order; 2) in a community or clinic setting through a partnership with the local public health department.*

### **Physician's Office**

*Physicians order home visits through the agency scheduler, who then arranges the appointment with the patient. The visit is set up as a medical provider consultation. The ordering provider will fax the scheduler a packet to include medication list, medical history, supporting documents, and other pertinent medical information. The Community Paramedic will respond to the order between 8:00 am and 5:00 pm within 24 – 48 hours of receipt, based on urgency. During the home visit, the Community Paramedic takes a patient history, assesses the chief complaint, and then confers with the treating provider on next steps. If the treating provider is unavailable for consultation, a call-down list triggered to assist the CP in getting the medical recommendations from either another physician within the practice or alternative physician according to policy (Appendix I.)*

*Once the visit has occurred, the Community Paramedic communicates to the physician through the patient care report, which then becomes a permanent part of the permanent medical record. Physicians may only order services, which are in within the program's scope of services (services within the Paramedics scope of practice, for which they have been trained and evaluated as able to perform satisfactorily). Visits are scheduled during regular business hours and initial visits are scheduled for one hour.*

### **Local Public Health Department**

*Community Paramedics may assist a local public health department with such services as immunizations, fluoride varnish application, blood draws for screenings, blood pressure checks and communicable disease investigations. The paramedic works with a registered nurse and the health department has oversight from the department's medical director, who should be a licensed physician. Community Paramedics may be of particular use for surge capacity during a disease outbreak when mass vaccination/prophylaxis and investigation is needed or when a clinic is short staffed. The Community Paramedic's agency and public health department should agree on a process for requesting the services of a Community Paramedic, to be coordinated through the scheduler.*

### **Evaluate the Pilot Phase**

*The program should plan to have a 1-2 month pilot phase to test how all of the systems are working. At the end of the pilot phase, the systems should be evaluated and mid-course corrections made. An evaluation of the pilot period can assess the following:*

*How the referral process is working for medical providers (interviews)*

*Response time of the Community Paramedics (tracking forms or EMR)*

*Client satisfaction (surveys or interviews) (Appendix D)*

*Quality assurance (case/chart reviews)*

*Program evaluation: Does patient database capture all the variables? (Database query)*

*Different aspects of this evaluation can be woven into an ongoing quality assurance plan and conducted on a regular basis.*

## **Appendix A**

### **Community Paramedicine Resources**

*Additional information and connections to national organizations, literature and other resources are provided below.*

*International Roundtable on Community Paramedicine: [www.IRCP.org](http://www.IRCP.org)*

*Joint Committee on Rural Emergency Care:  
National Association of State EMS Officials & National Organization of State Offices of Rural Health*

*Policy Brief on Integration of EMS into the Healthcare Delivery System, November 2009:*

*[www.nosorh.org/policy/files/jcrec\\_policy\\_brief.pdf](http://www.nosorh.org/policy/files/jcrec_policy_brief.pdf)*

*State Perspectives: Discussion Paper on Development of Community Paramedic Programs, 2010:*

*[www.nasemso.org/Projects/RuralEMS/documents/CPDiscussionPaper.pdf](http://www.nasemso.org/Projects/RuralEMS/documents/CPDiscussionPaper.pdf)*

*Community Health Care Emergency Cooperative's Community Paramedic*

*Curriculum: [www.communityparamedic.org/Colleges.aspx](http://www.communityparamedic.org/Colleges.aspx)*





## **APPENDIX C: Sample Provider Agreement**

### **MEMORANDUM OF UNDERSTANDING COMMUNITY PARAMEDIC PROGRAM**

This Community Paramedic Program Agreement (“Agreement”) is entered this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_, between (COMMUNITY PARAMEDIC PROGRAM) and (MEDICAL PROVIDER), herein being referred to collectively as, the “Participants.”

WHEREAS, the Participants share a mission to improve the health of residents in (NAME OF SERVICE AREA); and

WHEREAS, community paramedics are specially trained to conduct in-home patient assessments and provide specific primary health care and preventive services, by acting through a physician’s order and within a defined scope of practice; and

WHEREAS, the community paramedic model helps physicians monitor the health of vulnerable patients, thereby producing better health outcomes and reducing the number of ambulance transports, visits to the emergency department, and hospital readmissions; and

WHEREAS, medical providers are key to the community paramedic program in terms of providing clinical training and issuing orders; and

WHEREAS, (MEDICAL PROVIDER) desires to participate in (PROGRAM’S) Community Paramedic program.

NOW, THEREFORE, in consideration of the terms and conditions of this MOU, the receipt and sufficiency of which is jointly acknowledged, the Participants agree as follows:

#### **I. Scope of Work**

- a. (MEDICAL PROVIDER) agrees to provide a clinical rotation for a mutually agreed upon number of community paramedics, in the areas of family practice and pediatrics, based on the attached clinical rotation guidelines (Attachment A). Activities will include training then evaluating the community paramedic’s ability to correctly perform each procedure. (MEDICAL PROVIDER) may provide additional training hours if both parties agree that it would be mutually beneficial to the program.
- g. Participants agree to share patient records as is necessary to provide care, and will follow corresponding confidentiality policies. The patient record created by the community paramedic will be sent to the ordering physician at (MEDICAL PROVIDER).
- h. Participants agree to run data requests on certain measurable outcomes for use by both parties. Data will be presented in aggregate without patient identifiers. (CP PROGRAM) will share program evaluation results with (MEDICAL PROVIDER).
- i. (MEDICAL PROVIDER) providers shall formally request a home visit by the community paramedic through a physician order, based on services that are within the scope and expertise of the paramedic. A community paramedic will act on the order between 8:00 am and 5:00 pm within 24 – 48 hours of receipt, and based on urgency and availability, unless otherwise agreed upon by the issuing provider. (MEDICAL PROVIDER’S) physicians and medical providers shall provide medical oversight and have ultimate responsibility regarding their patients in the program.

### **Appendix C: Sample Provider Agreement, Continued**

- f. *(MEDICAL PROVIDER) shall provide a representative to the Community Paramedic Advisory Committee, which meets quarterly.*
- g. *(MEDICAL PROVIDER) shall participate in case reviews when appropriate, in order to improve the quality of the program and document specific outcomes for evaluation purposes.*
- h. *(CP PROGRAM) shall provide the medical oversight for the program through its Medical Directors, Kentucky-licensed physicians.*
- i. *(MEDICAL PROVIDER“S) participating physicians shall sign Attachment B agreeing that they understand the program and the procedures available to be performed. Attachment B can be amended with additions or deletions of physician’s signatures on an as needed basis without the need to change this agreement.*
- j. *(MEDICAL PROVIDER) shall provide proof of a certificate of liability insurance for Medical Malpractice listing all physicians participating in the program.*

#### **II. Insurance**

*Each party, shall, at no cost or expense to the other party, carry a policy or policies of professional liability insurance, comprehensive general insurance, and workers compensation insurance issued by an insurance carrier or self-insurance mechanism authorized by the Commonwealth of Kentucky in such amounts as are reasonably acceptable to each other. Said insurance policies shall cover officers, employees, agents and volunteer s of the Participants. If the liability insurance required by this section is on a “claims made” basis and at any time prior to the expiration of any statute of limitation period which might apply to acts, errors or omissions of a party during the term of this Agreement, or a party shall cease to maintain liability insurance required by this section or should switch insurance carriers, that party shall purchase from an insurance carrier acceptable to the other, a “tail” policy covering acts, errors or omissions during the term of this Agreement as to which claims may then still be asserted. If a party fails to purchase such tail coverage within 30 days after the termination of this Agreement, the other party shall have the right to purchase such coverage and bill the other for the premium.*

*Upon request, each party shall provide the other with certificate(s) of such insurance coverage and statement(s) from the insurance carrier that the certificate holder will be notified at least 30 days prior to any cancellation, non-renewal or change in such coverage. Failure by either party to maintain proper insurance coverage shall, at the option of either party, be grounds to immediately terminate this Agreement.*

#### **III. Compensation**

*The Participants understand that no compensation will occur for community paramedic services or the training they receive, unless a modification is made to this contract.*

#### **IV. Term of Agreement**

*The term of this Agreement shall be through the end of the year in which it is entered, and this Agreement shall be automatically renewed for additional one (1) year terms in perpetuity.*

V. *Termination of Agreement*

*Either party may terminate this Agreement at any time and for any reason in writing with thirty (30) days' notice.*

VI. *Amendment*

*This Agreement shall be binding on the Participants and represents the final and complete understanding of the Participants as regards the subject matter. This Agreement shall not be modified or amended unless in writing, executed by Participants.*

VII. *Waiver of Breach*

*No waiver by either party of any term, covenant, condition or agreement contained herein, shall be deemed as a waiver of any other term, covenant, condition or agreement, nor a waiver of breach thereof deemed to constitute a waiver of any subsequent breach, whether of the same or a different provision of this Agreement.*

VIII. *Counterparts*

*This Agreement may be executed in counterparts, each of which will be an original, but all of which together shall constitute one and the same instrument.*

IX. *Enforcement, Jurisdiction and Venue*

*This Agreement shall be governed and construed in accordance with the laws of the (STATE OF PROGRAM, and in addition to any other remedy, may be specifically enforced. Jurisdiction and venue for any suit, right or cause of action arising under, or in connection with this Agreement shall be exclusive in (LOCATION OF PROGRAM, STATE).*

X. *Responsibility for Acts of Employees and Promise to Indemnify*

*Each party will be solely responsible for its acts and omissions and the acts and omissions of its employees, agents, officers and volunteers in the performance of its obligations under this Agreement, and shall indemnify and hold the other party harmless from and against any and all demands, losses, liabilities, claims, or judgments, costs and expenses, including but not limited to reasonable attorney's fees, arising out of any act or omission of the party, its employees, agents, officers and volunteers in the performance of its obligations under this Agreement.*

XI. *Third Party Beneficiary*

*Nothing herein expressed or implied is intended or should be construed to confer or give to any person or entity other than (CP PROGRAM) or (MEDICAL PROVIDER) and their respective successors and assigns, any right, remedy or claim under or by reason hereof of by reason of any covenant or condition herein contained.*

XII. *Notices*

*Any formal notice, demand or request pursuant to this Agreement shall be in writing and shall be deemed properly served, given or made, if delivered in person or sent by certified mail postage prepaid to the Participants at the following addresses or as otherwise modified pursuant to this section:*

*If to (CP PROGRAM):  
(ADDRESS)*

*If to (MEDICAL PROVIDER):  
(ADDRESS)*

*with a copy to:  
(LEGAL COUNSEL)*

*with a copy to:  
(LEGAL COUNSEL)*

*XIII. Severability*

*In the event that any of the terms, covenants or conditions of this Agreement or their application shall be held invalid as to any person, entity or circumstance by any court having competent jurisdiction, the remainder of this Agreement and the application in effect of its terms, covenants or conditions to such persons, entities or circumstances shall not be effected thereby.*

*XIV. Section Headings*

*The section headings in this Agreement are inserted for convenience and are not intended to indicate completely or accurately the contents of the sections they introduce and shall have no bearing on the construction of the sections they introduce.*

*XV. Duly Authorized Signatories*

*By execution of this Agreement, the undersigned each individually represent that he or she is duly authorized to execute and deliver this Agreement and that the subject party shall be bound by the signatory's execution of this Agreement.*

*IN WITNESS WHEREOF the Participants have caused this Agreement to be executed as of the day and year written above.*

*(PROGRAM)*

*By:*

*Title:*

*ATTEST:*

*(MEDICAL PROVIDER)*

*By:*

*Title:*

*ATTEST:*

## Appendix D

### Sample MOU: Attachment A Continued Community Paramedic Clinical Procedures

#### Family Practice Clinical Rotation

40 Hours Clinical Time (L1)

<i>PROCEDURES LEVEL 1</i>	<i># Performed</i>	<i>Clinical Site</i>
<i>Blood Pressure checks</i>	2	<i>FP</i>
<i>Medical Equipment</i>		<i>FP</i>
<i>Otoscope</i>	30	<i>FP</i>
<i>Blue Tooth Stethoscope</i>	5	<i>FP</i>
<i>Home Medication</i>		<i>FP</i>
<i>Compliance</i>	7	<i>FP</i>
<i>Medication Reconciliation</i>	7	<i>FP</i>
<i>Pt Documentation</i>		<i>FP</i>
<i>SOAP Notes</i>	5	<i>FP</i>
<i>Chart Review</i>	15	<i>FP</i>
<i>History &amp; Physical</i>	20	<i>FP</i>
<i>Assessment</i>	20	<i>FP</i>
<i>Results from Tests/Diagnostic tools</i>	15	<i>FP</i>
<i>Identifying Red Flags</i>	5	<i>FP</i>
<i>Identifying further testing needs</i>	5	<i>FP</i>
<i>Prenatal</i>		<i>FP</i>
<i>Doppler</i>	5	<i>FP</i>
<i>Measurements</i>	5	<i>FP</i>
<i>Urine for Protein</i>	5	<i>FP</i>
<i>Acute Illness Management</i>		<i>FP</i>
<i>0-1 years</i>	5	<i>FP</i>
<i>1-5 years</i>	5	<i>FP</i>
<i>6-13 years</i>	5	<i>FP</i>
<i>14-18 years</i>	5	<i>FP</i>
<i>18 + years</i>	5	<i>FP</i>
<i>65 + years</i>	5	<i>FP</i>

## Appendix D

### Client Satisfaction Survey

*It is our goal to maintain the highest level of customer service, training, skills, and compassion to all of our patients and families. Please take a few moments and complete this short survey. Your responses will be assured confidentiality.*

*Reason for Service: 911 Call 0 Community Paramedic 0 Transferred from Clinic to Hospital 0 Visti*

*Please rate the following areas on a scale of 1 - 5 (1 Strongly Dissatisfied to 5 Very Satisfied) Circle only one answer per line.*

	<i>Strongly Dissatisfied</i>	<i>Dissatisfied</i>	<i>Neutral</i>	<i>Satisfied</i>	<i>Very Satisfied</i>	
<i>Courtesy of the 911 call operator</i>	1	2	3	4	5	N/A
<i>Usefulness of instruction provided by the 911 call operator prior to the Paramedics</i>	1	2	3	4	5	N/A
<i>Professionalism / appearance of Paramedics</i>	1	2	3	4	5	N/A
<i>Quality of care provided by Paramedics</i>	1	2	3	4	5	N/A
<i>Cleanliness of ambulance and equipment</i>	1	2	3	4	5	N/A
<i>Overall satisfaction</i>						
<i>Satisfaction with care you received at Emergency Room after we ended our care</i>	1	2	3	4	5	N/A

*If you do have a concern about our services provided, please contact our office and speak with \_\_\_\_\_ or we will call you back at the number you provide.*

*Name:*

*Phone:*

*Please provide name and phone number. (Optional and Confidential)*

*Additional Comments:*

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*Thank you for your time and comments about our service.*

## Appendix E: National Fact Sheet



### Opportunity Statement

- *Severe Primary Care Shortage currently exists and is on the rise*
- *Vulnerable populations with new health insurance plans will not have access to a provider because of the increase in demand*
- *Cost of healthcare continues to rise with Emergency Rooms being the most available alternative*
- *Access to care problems are exacerbated in rural areas due to higher healthcare provider shortages, a larger elderly population than urban, and transportation barriers*

### Community Paramedic Solution

*The Community Paramedic model is an innovative, proven solution to provide high quality primary care and preventative services by employing a currently available and often underutilized healthcare resource.*

### How does it Work?

*A primary care partner refers a patient to Emergency Medical Services (EMS) personnel to provide services in the home that are within their current scope of practice including: hospital discharge follow-up, fall prevention in the home, blood draws, medication reconciliation or wound care. The Community Paramedic provides care and communicates health records back to the referring physician to ensure quality of care and appropriate oversight. In addition works with Public Health to provide preventative services throughout the community.*

### Advantages

- *Decreases workload and increases quality and efficiency of managing patients in a primary care and public health settings by utilizing EMS Personnel through non-traditional methods*
- *EMS personnel are integrated throughout the healthcare system, improving access and decreasing healthcare cost*
- *Community Paramedic certification provides a job opportunity where EMS volunteer work is often the only sustainable model in rural areas*
- *EMS personnel currently have the training, expertise and scope of practice to provide essential patient care services*
- *The program has a proven track record locally and internationally*

### Frequently Asked Questions

*Q: Does a Community Paramedic replace current healthcare systems like home health care or primary care Physicians?*

*A: No. Community Paramedic is an extension of the primary care provider to provide care to patients without access, and does not replace the specialized services available in a home health care model or physician office.*

*Q: Does a Community Paramedic have the right training to provide primary care?*

*A: Additional training is provided to Community Paramedics specific to providing preventive care in the home within their current scope. However, services provided do not fall out of the currently defined scope of practice for EMS personnel.*

*Q: Is the quality of care compromised by using a Community Paramedic vs. a primary care provider?*

*A: No. A Community Paramedic provides care under the supervision of a physician, so the quality of care is consistent with care provided in a clinic setting.*

## **Appendix F**

### *Community Paramedic Fact Sheet*

#### *Problem Statement:*

*Access to healthcare and particularly primary care services is a growing concern. Primary care providers are in short supply, and the uninsured population is on the rise.*

*Uninsured patients are less likely to seek out preventive care services, and are more likely to go to the emergency room for non-urgent care, increasing the cost of healthcare.*

*In rural areas, the problem is exacerbated because of a higher rate of uninsured, compared to urban settings, and shortage of healthcare providers.*

#### *Opportunity:*

*To address the decrease in access to primary care services, it is necessary to evaluate current resources within communities and explore innovative solutions. The Community Paramedic model is a proven solution that provides essential primary care services for vulnerable populations.*

*Paramedics have the training, expertise and scope of practice to provide primary care services such as assessments, blood draws, wound care, diagnostic cardiac monitoring, fall prevention, medication reconciliation, and post-operative follow up. They also have the experience of taking health care into the home.*

*Internationally, Community Paramedic programs have demonstrated increased health outcomes and cost savings. Many countries are providing Emergency Medical Service (EMS) personnel with additional training to expand into community-based services.*

*EMS personnel are already integrated throughout the healthcare system, allowing them to easily provide primary care services within their scope of practice.*

#### *What the Community Paramedic model offers:*

*Enhanced utilization of a healthcare resource under the current scope of practice.*

*Increased efficiency in terms of managing patients in a primary care setting.*

*Coordinated and integrated care with physician's offices, hospitals, home health agencies, long term care facilities, and public health departments.*

#### *The Community Paramedic model will NOT:*

*Replace current healthcare systems or positions.*

*Change the current defined scope of practice of the EMS Personnel.*

*Remove patient populations from healthcare providers.*

*Decrease the level of care provided.*

## Appendix G

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### *Community Paramedic Patient Referral Guide*

- 1. Provider talks with patient about follow-up with a community paramedic.*
- 2. Provider requests patient sign the consent/authorization to release health information form.*
- 3. Provider completes the community paramedic patient referral form and lab form if indicated. (Use existing laboratory request form, as this is the form the lab will receive with the specimen.)*
- 4. Provider faxes the following to the CP Patient Scheduler: Release of information form, current history and physical, medication history, hospital discharge orders, immunization records or any other medical record applicable to the community paramedic visit. (Please include the patient's medical record number.)*
- 5. Scheduler will verify with physician that all information has been received.*
- 6. The community paramedics will make every effort to see the referred patient within 48 hours of the referral unless the patient is in urgent need of medical follow-up.*
- 7. Scheduler will call the patient to arrange appointment time/date.*
- 8. Scheduler will coordinate with the community paramedics to arrange patient visit.*
- 9. Scheduler will call or fax the appointment dates to the provider offices once a week.*
- 10. Community Paramedic will complete patient visit at appointment time arranged.*
- 11. Community Paramedic will complete patient care report.*
- 12. Scheduler will fax patient care report back to provider office within 24 hours of visit.*

Appendix H

Release of Information Form

PATIENT INFORMATION

I

PLEASE RETURN BY FAX TO XXX-XXX-XXXX

Patient's Last Name

First

Middle

DOB

INFORMATION

Consult

labs

Immunization Record

Discharge Summary

Physician Progress Notes

Other as specified below:

Emergency Department Report

M RI Report

EKG Tracings

Operative Report

Graphic Record

X-Ray Report

History and Physical

X-Ra y

MRI Date of Order:

Purpose of Release:

This consent/authorization is to release health information from and to:

Name

I Phone Number

Address

City

State

Zip Code

This consent/authorization will remaining effect

- From the date it is signed out until:

- Until the following event occurs:

Note: IF neither of the above options is selected, this consent/authorization will remain in effect for 180 days from the date this it is signed.

I authorize m y health information described above to be released to (Service Name) Community Paramedic Program to send all copies of my health record back to the above named entity for the purpose of continuity of care and understand that:

1. Information disclosed pursuant to this Consent/Authorization may include information relating to sexually transmitted disease, AIDS/HIV, and physiological or psychiatric conditions, unless restricted as follows:
2. Once information is disclosed pursuant to this signed Consent/Authorization, I understand that the federal privacy law (45 C. F.R parts 160 and 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from disclosing it.
3. I may revoke this Consent/Authorization at any time, except to the extent that act ion has been taken in reliance on it. To revoke it, I must provide the Privacy Officer-at the address listed at the top left of this form-with a written revocation which will not be effective until received and approved by the Privacy Officer.
4. I may refuse to sign this Consent/Authorization and this refusal will not affect the Treatment of the Community Paramedic Program provides to the patient, unless the patient is seeking health care services solely for the purpose of creating health information for disclosure to a third party.

Signature of Patient/Parent of Legal Representative

Date

If signed by Legal Representative, legal Representative's authority to act on behalf of patient: Relationship to patient:

For Office Use ONLY

DATE INFORMATION RELEASED

MEDICAL RECORD NUMBER

## **Appendix I**

### *Physician Contact While at Visit*

*Last Revised: (Date)*

*Purpose: This policy is in place in the event a Community Paramedic is at a visit with a patient and a physician needs to be contacted immediately, but the ordering physician is not available.*

*Procedure: Always begin by calling the ordering physician first. If they are unavailable, proceed through the call down list in the order provided below.*

- 1. Call the ordering physician's on-call service*
- 2. Call the ambulance services medical control at the hospital*
- 3. Call the ambulance services medical director on their mobile phone*

## **Appendix J**

### *Home Safety Assessment*

*Last Revised: (Date)*

*Purpose: The home safety assessment is designed to provide a detailed walkthrough of the client's home, identify safety hazards and make recommendations when needed.*

*Procedure: The paramedic will look at many factors that have been shown to cause injuries to members of the home, especially the very young and elderly. With a specially designed checklist, (Attachment A) the assessment begins at the driveway or walkway and ends at the back yard. Note, this assessment is not a mechanical inspection of the home and is not designed to look at the safety of electrical wiring, hot water heaters, plumbing or any other mechanical features of the house. Rather, it is designed to focus on things such as trip hazards, kitchen safety, adequate lighting in the home and in walk areas, grab bars and lift handles if applicable, and other notable safety features.*

*A Community Paramedic does not perform the role of a physical therapist and will therefore not be analyzing the persons gait or movement, nor advising about exercises or physical therapy. If a Community Paramedic notices the client is having difficulty moving around, they should make the necessary referrals to organizations that can provide walkers, canes and other mobility devices, and also link them with their primary care physician, so that they can be referred to a physical therapist. If hazards are found, the paramedic will recommend changes that need to be made and, if needed, refer the client to the appropriate community resources that can then provide further assistance.*

## ATTACHMENT A

### Home Safety Assessment Checklist

Date of visit:

Occupant name:

Paramedic Name:

#### OUTSIDE OF HOUSE

- |   |     |    |     |
|---|-----|----|-----|
| 1. Sidewalk and/or pathway to house is level and free from any hazards. | Yes | No | N/A |
| 2. Driveway is free from debris/snow/ice.                               | Yes | No | N/A |
| 3. Outside stairs are stable and have sturdy handrail.                  | Yes | No | N/A |
| 4. Porch lights are working and provide adequate lighting.              | Yes | No | N/A |

#### LIVING ROOM

- |   |     |    |     |
|---|-----|----|-----|
| 1. Furniture is of adequate height and offers arm rests that assist in getting up and down.       | Yes | No | N/A |
| 2. Floor is free from any clutter that would create tripping hazards.                             | Yes | No | N/A |
| 3. All cords are either behind furniture or secured in a manner that does not cause trip hazards. | Yes | No | N/A |
| 4. All rugs are secured to floor with double-sided tape.  | Yes | No | N/A |
| 5. Lighting is adequate to light room.  | Yes | No | N/A |
| 6. All lighting has an easily accessible on/off switch.   | Yes | No | N/A |
| 7. Phone is readily accessible near favorite seating areas.                                       | Yes | No | N/A |
| 8. Emergency numbers are printed near all phones in house.  | Yes | No | N/A |

#### KITCHEN

- |  |     |    |     |
|--|-----|----|-----|
| 1. Items used most often are within easy reach on low shelves. | Yes | No | N/A |
| 2. Step stool is present, is sturdy and has handrail.          | Yes | No | N/A |
| 3. Floor mats are non-slip tread and secured to floor.         | Yes | No | N/A |
| 4. Oven controls are within easy reach.                        | Yes | No | N/A |
| 5. Kitchen lighting is adequate and easy to reach switches.    | Yes | No | N/A |
| 6. ABC fire extinguisher is located in kitchen.                | Yes | No | N/A |

Home Safety Checklist, cont.

**STAIRS**

- |  |     |    |     |
|--|-----|----|-----|
| 1. Carpet is properly secured to stairs and/or all wood is properly secured. | Yes | No | N/A |
| 2. Handrail is present and sturdy.   | Yes | No | N/A |
| 3. Stairs are free from any clutter.   | Yes | No | N/A |
| 4. Stairway is adequately lit.   | Yes | No | N/A |

**BATHROOM**

- |  |     |    |     |
|--|-----|----|-----|
| 1. Tub and shower have a non-slip surface.   | Yes | No | N/A |
| 2. Tub and/or shower have a grab bar for stability.  | Yes | No | N/A |
| 3. Toilet has a raised seat.   | Yes | No | N/A |
| 4. Grab bar is attached near toilet for assistance.  | Yes | No | N/A |
| 5. Pathway from bedroom to bathroom is free from clutter and well lit for ease of movement in the middle of the night. | Yes | No | N/A |

**BEDROOM**

- |   |     |    |     |
|---|-----|----|-----|
| 1. Floor is free from clutter.                  | Yes | No | N/A |
| 2. Light is near bed and is easy to turn on.    | Yes | No | N/A |
| 3. Phone is next to bed and within easy reach.  | Yes | No | N/A |
| 4. Flashlight is near bed in case of emergency. | Yes | No | N/A |

**GENERAL**

- |  |     |    |     |
|--|-----|----|-----|
| 1. Smoke detectors in all areas of the house (each floor) and tested.  | Yes | No | N/A |
| 2. CO detectors on each floor of house and tested.   | Yes | No | N/A |
| 3. Flashlights are handy throughout the home.  | Yes | No | N/A |
| 4. Resident has all medical information readily available and in an area emergency providers will easily find. | Yes | No | N/A |
| 5. All heaters are away from any type of flammable material.   | Yes | No | N/A |

OVERALL TIPS

- |   |     |    |     |
|---|-----|----|-----|
| 1. Homeowner has good non-skid shoes to move around house.  | Yes | No | N/A |
| 2. All assisted walking devices are readily accessible and in good condition. Yes   |     | No | N/A |
| 3. There is a phone near the floor for ease of reach in case of a fall.   | Yes | No | N/A |
| 4. All O2 tubing is less than 50 ft. and is not a trip hazard.  | Yes | No | N/A |
| 5. Resident has had an annual hearing and vision check by a physician.  | Yes | No | N/A |
| 6. Resident has the proper hearing and visual aids prescribed and are in good working order.                                  | Yes | No | N/A |
| 7. All medications are properly stored and labeled to avoid confusion on dosage, time to take, and avoidance of missed doses. | Yes | No | N/A |

FOR ALL SECTIONS MARKED 'NO' THE FOLLOWING RECOMMENDATIONS ARE NOTED BELOW

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After evaluation I recommend the resident be considered for the following referrals.

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Signature of resident:

Signature of Community Paramedic:

References: Centers for Disease Control and Prevention / <http://www.cdc.gov>

A. „Check for Safety“ A Home Fall Prevention Checklist for Older Adults

B. U.S. Fall Prevention Programs for Seniors – Selected Programs Using Home Assessment and Modification.

## **Appendix K**

### *Support Evaluation*

#### *Social*

*Last Revised: (Date)*

*Purpose: The social evaluation procedure is designed for use during the home visit for the Community Paramedic to determine whether the client has the social supports necessary to help maintain their health.*

*Procedure: The Community Paramedic will use history taking and other interview techniques to assess the client's general wellbeing in the home, and make sure that this is a person who has all of their basic needs met. The Community Paramedic will assess such necessities as adequate food, cleanliness, clothing, shelter, companionship, supportive social network, ability to obtain prescription medications (financially and physically in terms of being able to retrieve/open them), and other important day-to-day needs. Referrals will be made to the appropriate agencies when appropriate, and a detailed report will be given to the physician after the Community Paramedic visit.*

### *Wound Check/Dressing Change*

*Last Revised: (Date)*

*Purpose: To perform an evaluation of a wound and to assist the patient and family caregivers in the changing of basic dressings in the home setting.*

*Procedure: In caring for a patient who has a wound that needs to be evaluated and have a dressing changed, the Community Paramedic will perform a history, physical, and basic evaluation of the wound to make sure that there is no infection or other obvious signs of immediate need for physician evaluation. Basic dressing changes will be performed, however, there will be no advanced care of the wound such as draining or debriding. If during the visit it appears that the wound needs any type of advanced care, the Community Paramedic will contact the physician's office and recommend that the patient be seen as soon as possible.*

### *Medication Compliance and Reconciliation*

*Last Revision: (Date)*

*Purpose: The purpose of this service is to evaluate the patient's medications to determine whether they are taking and storing them correctly. Elderly patients in particular may be on multiple medications, which can create confusion. The CP will evaluate whether the patient is taking each one of their prescribed medications, at the appropriate time and correct dosage, and whether they are safely and properly storing them. The goal for the Community Paramedic is to help the client organize and correctly understand how and when to take their medications.*

*Procedure: Before visiting with the patient, the physician's office will fax a copy of the most current medication list, history and orders to the Community Paramedic office so that the visiting paramedic knows exactly what plan the patient is supposed to be on. Through inspection of the medications, organizational containers and interview techniques, the paramedic will determine if the patient is following their prescribed medications and routine. If, during the visit, the paramedic finds that there is a discrepancy in how the patient is handling their medications, the physician will be contacted and discussions will be made on how to correct the problem. The paramedic will NOT change any medications, dose, or advise the patient on how to resume a normal schedule once the patient has gone off their prescribed meds or routine. The physician will make any and all decisions regarding the patient's medications, and the paramedic is in an assistance role only.*

**Appendix M**

Community Paramedic Patient Order Form

<b>PATIENT INFORMATION</b> <i>(May submit patient face sheet for demographics)</i>		<b>PLEASE RETURN BY FAX TO xxx-xxx-xxxx</b>	
Date of Order: _____		Requested Date of Service: _____	
Client Name: Last _____		Primary Language: _____	
M F		DOB: _____	
First _____		Gender: <input type="checkbox"/> <input type="checkbox"/>	
Middle _____			
Physical Street Address _____		City/Town _____	
Mailing Address (if different) _____		State _____	
		Zip Code _____	
Insurance (For research purposes only): No <input type="checkbox"/>		Yes <input type="checkbox"/> If _____	
<b>DIAGNOSIS</b>		<b>PREVENTION ASSESSMENTS</b>	
Diagnosis : _____		Nutrition Assessment <input type="checkbox"/>	
Reason for Visit: _____		<input type="checkbox"/> Social Evaluation / Social Support	
		<input type="checkbox"/> Home Safety Inspection	
<b>LABORATORY SPECIMEN COLLECTION</b>		<b>PLEASE INCLUDE AGENCY CLINICAL LAB TESTING ORDER</b>	
<input type="checkbox"/> Blood Draw		<input type="checkbox"/> iStat Test (Coming Soon!)	
<input type="checkbox"/> Requested Labs/Blood Tubes: _____		<input type="checkbox"/> Stool Collection	
		<input type="checkbox"/> Urine Collection	
<b>CLINICAL CARE</b>			
<b>Cardiovascular</b>		<b>Respiratory</b>	
<input type="checkbox"/> Blood Pressure Check		<input type="checkbox"/> Asthma Meds/Education/Compliance	
<input type="checkbox"/> H&P EKG 12 Lead		<input type="checkbox"/> CPAP	
<input type="checkbox"/> Peripheral Intravenous Lines		<input type="checkbox"/> MDI Use	
<input type="checkbox"/> Compliance		<input type="checkbox"/> Nebulizer Usage/Compliance	
<input type="checkbox"/> Follow-up/Post Discharge		<input type="checkbox"/> Peak Flow Meter Education/Usage	
<input type="checkbox"/> Diabetic Follow-up/Education		<input type="checkbox"/> Oxygen Saturation Check	
<input type="checkbox"/> Neurological Assessment		<input type="checkbox"/> Weight Check	
<input type="checkbox"/> Dressing Change/Wound Check/Type: _____			
Discharge Follow-up/Diagnosis: _____			
Other Orders/Information: _____			
_____			
<b>PUBLIC HEALTH/SOCIAL SERVICES</b>			
<input type="checkbox"/> Bright Beginnings		<input type="checkbox"/> EHS Post Partum Visit	
<input type="checkbox"/> Disease Investigation		<input type="checkbox"/> Fluoride Varnish Clinic	
<input type="checkbox"/> IZ Clinic Coverage		<input type="checkbox"/> Welfare Check	
<input type="checkbox"/> TB Meds DOT			
<b>ORDERING PHYSICIAN SIGNATURE</b>		<b>Disclaimer: All visits will be accomplished as soon as possible but generally within 24 – 72. All services provided must be within the scope of practice of a paramedic as described in 6 CCR 1015-3 Chapter 2, EMS Practice and Medical Director Oversight Rules. Paramedics will verify that orders fall within this scope of practice and will contact you if orders need clarification or further instruction.</b>	
Contact Number: _____			
Referring Physician: _____ (Please Print)			
<input type="checkbox"/> Fax report to: _____			