Enabling Community Paramedicine While Protecting the Public: Thoughts on Legislation and Regulation in the US

Kevin McGinnis, Paramedic Chief (Ret.)
Program Manager
Community Paramedicine/MIH and Rural EMS
National Association of State EMS Officials

State EMS Agencies

Vision
A seamless nationwide network of coordinated and accountable state, regional and local EMS and emergency care systems. The systems use public health principles, data and evidence as a basis for safe and effective care……

Roles
Encouraging, Enabling, Planning and Leading System Growth

Protecting the Public

Operations
Limited (Regulatory)
Intermediate (System Planning/Leadership/Regulation)
Broad/Active (e.g. Maryland, Idaho)

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The National Association of

https://www.nasemso.org/Projects/MobileIntegratedHealth/Documents-Resources.asp

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Community Paramedicine - Mobile Integrated Health Documents & Resources

Click Here for The Latest Published CP-MIH Articles

Click Here for the Latest CP-MIH News

Thanks to the Ramsey Social Justice Foundation Which Supports the Notion That Emergency Medical Services and Healthcare Are Rights For All People

Community Health Needs Assessments Resources for Community Paramedicine/Mobile Integrated Healthcare (05/19/17)

State CP Status Board and Map

Community Paramedicine Articles/Papers

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RAMSEY SOCIAL JUSTICE FOUNDATION

MEDICAL EDITION

"Emergency Medical Service and Healthcare Are Rights For All People"
- Bob Ramsey

Category Archives: *Community Paramedicine Articles*

We are pleased to have this great resource at Ramsey Social Justice Foundation. We will continue to add and update articles and share ideas with the Community EMS world. We hope this stimulates thought and contributes to the great changes that are upon us now. As EMS transitions from being the American safety net of crisis medicine to being part of the overall healthcare system with the Affordable Healthcare Act.

Catherine R. Eden, Ph.D.
V.P. Director
Community Based EMS

Community Paramedicine Blog

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"Emergency Medical Service and Healthcare Are Rights For All People"
- Bob Ramsey

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October 13, 2017 - Flirtey Partners with Ambulance Service to Launch First Emergency Drone Delivery Program in U.S.

October 11, 2017 - Inventors present drone that could help treat patients in disasters

October 11, 2017 - Drones to deliver defibrillators to 911 callers to treat cardiac arrest

October 9, 2017 - HHS Commits $144.1 Million in Additional Funding for Opioid Crisis

October 9, 2017 - Ill. Firefighter-Paramedics Improve Patient Outcomes with Lucas CPR Device

September 6, 2017 - Interacting With the Mental Health Crisis Victim

September 5, 2017 - The Stroke Revolution and Pivotal Role of EMS

August 31, 2017 - Study: Only 3.3 percent of ER visits are 'avoidable'

August 28, 2017 - Dayton International Airport unveils CPR training kiosk

August 28, 2017 - N.Y. First Responders Travel to Tex. to Assist in Hurricane Harvey Rescues

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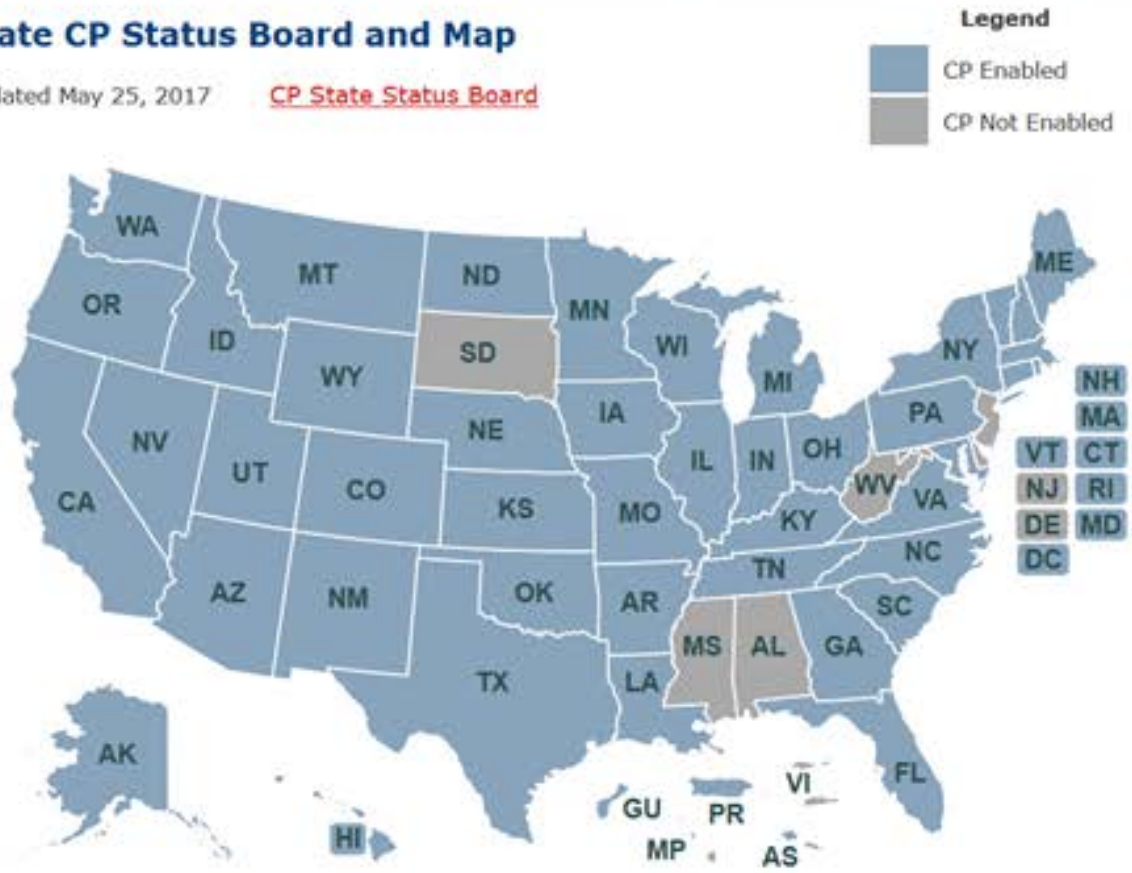
REPLICA

Recognition of EMS Personnel Licensure Interstate CompAct

State CP Status Board and Map

Updated May 25, 2017 CP State Status Board



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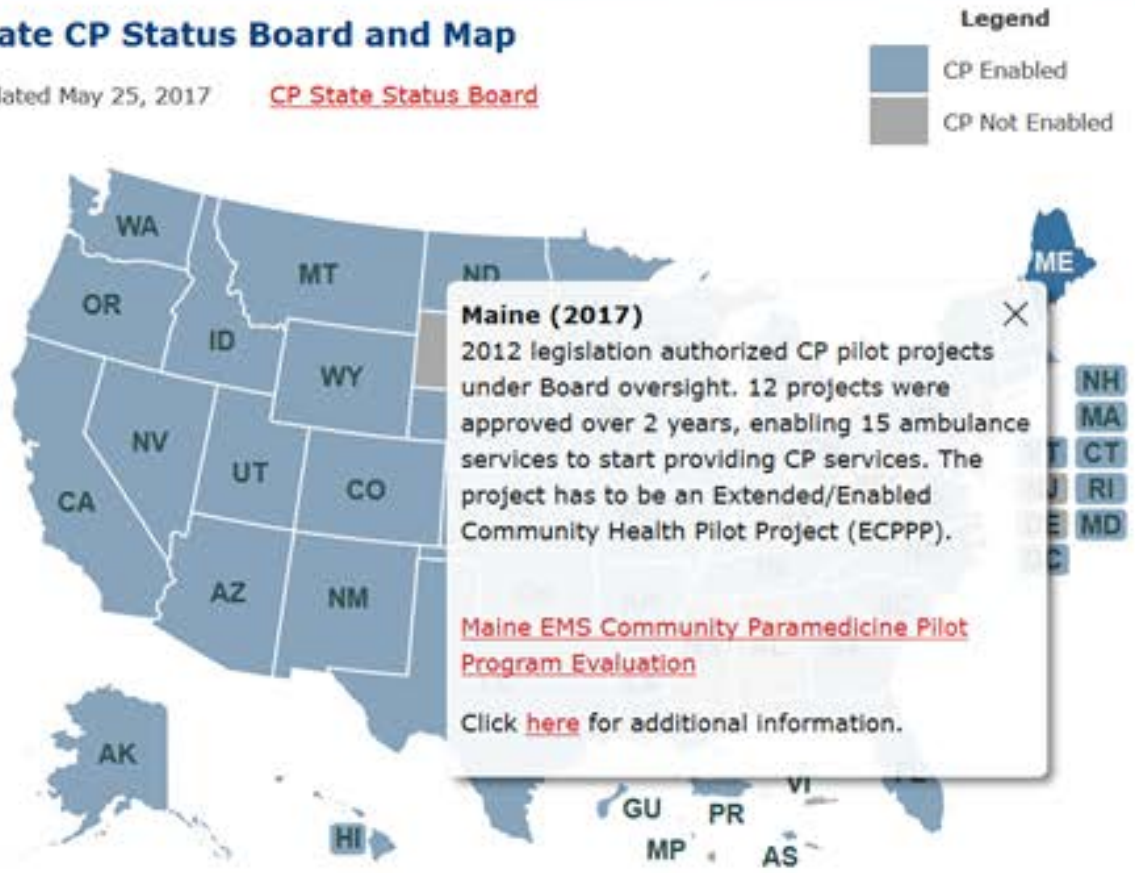


Maine (2017)

2012 legislation authorized CP pilot projects under Board oversight. 12 projects were approved over 2 years, enabling 15 ambulance services to start providing CP services. The project has to be an Extended/Enabled Community Health Pilot Project (ECPPP).

Maine EMS Community Paramedicine Pilot Program Evaluation

Click here for additional information.

To view information on all States CLICK HERE

Maine

Activity Reported:	Maine held its first statewide CP stakeholders meeting in 2011. A CP committee was formed as well as a leadership group which served to review and approve pilot projects. An Attorney General opinion that the Maine EMS Board did not have authority to approve and oversee CP or other non-emergency/non-transport activities of EMS providers led to 2012 legislation authorizing CP pilot projects under Board oversight. Twelve projects were approved over two years, enabling 15 ambulance services to start providing CP services. The project has to be an "Extended/Enabled Community Health Pilot Project (ECPPP)" which provides a specific type of CP service(s) employing any level of EMS providers, or a General Practice CP Pilot project (GPCPPP) employing paramedics who have graduated from a college-based CP course. To date, all projects are the former. When new legislation removed the limit on the number of projects, three additional projects were approved.
Enabling Legislation:	Initial authorization for CP was enacted during the125th Legislature, 2nd Regular Session (2012), LD 1837 (PL 562). This authorization set a cap of 12 pilot projects for a maximum of three years. During the 127th Legislature, 1st Regular Session (2015), LD 629 (PL 92), the CP statute was amended to eliminate the

Enabling/Facilitating/ Regulating Language of Rules/Regulations:	Only the definition of "pilot projects" which may be found on the CP application form.
Medicaid Support Sought:	Maine EMS and CP services have asked MaineCare (Medicaid) to reimburse for CP services. It already reimburses for non-transported diabetic calls treated and released on scene. MaineCare was planning to do a cost study in Fall, 2016 to be followed by reimbursement for CP services. This did not happen. There are 2 bills now in front of the legislature regarding CP funding: one to force the cost study, another to fund CP services. A third bill would make CP permanent (removing "pilot projects" status) and

	charge the Board with promulgating rules regarding application and licensure.
3rd Party Payer Support Sought:	Not as yet.
Health Systems Supporting CP Activities:	Central Maine Health, Maine General Health, and Eastern Maine Health systems all have CP programs with affiliated ambulance services. Specific hospitals/health services with CP ambulance services or sponsoring CP services (some of which may be affiliated with the above health systems) include: Maine Health Care at Home, Lincoln Health Home Care, C.A. Dean

State Benchmarking Activity:	Pilot projects require performance measurement appropriate to the types of services provided under the limited pilot projects. It prescribes specific benchmarks for the full CP projects, but there are none yet. A study of Maine EMS pilots was conducted by the University of Southern Maine in 2015.
Education/Training Requirement:	ECPPP projects need to have training specific to the service(s) being provided. A GPCPPP project must use paramedics with a college-based CP course (the 300 hour national consensus curriculum has been widely employed through distance learning with Hennepin Community College in Minnesota).
Regional/Statewide Stakeholder Meetings Used to Introduce CP-MIH? Lessons learned?	**Yes**. Invited "those who were expected to love it, hate it, or just find out more about opportunities it might provide". Over 70 participated from EMS, hospitals, nursing, home health care, medical and hospital associations, and other professional groups as well as Medicaid program and one third party payer. **Lessons learned**: Invite as above ("love, hate…"). Bring in outsiders with experience in established systems: someone who can explain the concepts and various ways applied across country to date, professionals from groups whose professions might be threatened or otherwise opposed (e.g. a doctor, a nurse – especially a home health or public health provider, a nurse practitioner working in a CP-MIH program). Make sure that the deepest, darkest concerns come out through good facilitation and are openly discussed by the outsiders and audience. Once the meeting further identifies where resistance is going to come from, plan to "meeting" that resistance until it goes away (it will with the logic of the CP-MIH approach to

Community Gap Analysis/ Needs Assessment Requirement:	There is a requirement that a pilot project describe the community health need targeted and demonstrate that it has coordinated with primary care providers in the area to be served.
Community Gap Analysis/ Needs Assessment Resources:	Maine has a health needs assessment partnership among some of the major health systems which produced a county by county gap analysis.
CP Medical Director Requirement:	A qualified primary care provider and an emergency medical services provider are required.
Patient Care Record Requirement:	State run record is required and has a "Community Paramedic" run type. ImageTrend state ePCR is used, though services may use other software, usually Zoll, as long as it can be uploaded to state data base.
EMS Agencies Providing CP:	North East Mobile Health Services*, United Ambulance, Winthrop Ambulance, Delta Ambulance, Central Lincoln County Ambulance, Waldoboro Ambulance, Boothbay Regional Ambulance Service, Belfast Ambulance, Castine VFD First Responders, Calais FD Ambulance, C.A. Dean Hospital Ambulance Service, Mayo Regional Hospital EMS, Crown Ambulance*, North Star EMS, MedCare Ambulance, Memorial Ambulance Corps. **approved pilot site, but not currently providing CP services*
Documents Available:	Pilot Project Application Study of Maine EMS Pilots
State EMS Office CP Contact:	Shaun St. Germain Director, Maine EMS (207) 626-3865

Rules, Regulations, and Legislation Summary

State	What?	Additional Information
Arkansas	Enabling Legislation	*Act 685, House Bill 1133* An Act to Create a Program for Licensure of Community Paramedics; and for Other Purposes. To Create a Program for Licensure of Community Paramedics.
Colorado	Enabling Legislation	*Senate Bill 16-069* Concerning Measures to Provide Community-Based Out-of-Hospital Medical Services, and, in Connection therewith, Making an Appropriation.
Connecticut	Enabling Legislation	*House Bill 7222* An Act Concerning the Department of Public Health's Various Revisions to the Public Health Statutes.
Iowas	Enabling Legislation	*Code, Chapter 147A* Emergency Medical Care – Trauma Care *Code, Section 641, Chapter 131* Emergency Medical Services – Provider Education/Training/ Certification *Code, Section 641, Chapter 132* Emergency Medical Services – Service Program Authorization
Maine	Enabling Legislation	*S.P. 222 – L.D. 629* An Act Regarding Community Paramedicine Pilot Projects
Massachusetts	Enabling Legislation	*Outside Section 93* Mobile Integrated Health Care
Minnesota	Defining & Enabling CP Enabling Medicaid Payment for CP	*Statute 256B.0625, Subdivision 60* Community Paramedic Services *Statute 144E.28, Subdivision 9* Certification of EMT, AEMT, and Paramedic

Community Health Needs Assessments: Resources for Community Paramedicine & Mobile Integrated Healthcare

May 2017

NASEMSO CP-MIH COMMITTEE

Statutory Approaches

- Delegated Practice vs. Scope of Practice (e.g. Texas)
- No Statutory Change/Current Definitions Work as Long as Within Scope of Practice (Many; some have regulatory changes needed, e.g. WY)
- Statutory Changes Needed for Practice and/or Reimbursement ("Emergency" Impediment)
  - CP (e.g. MN, ME, CO)
  - MIH (MA, CO)

WYOMING RULES ESTABLISHMENT

CHAPTER 14

COMMUNITY EMS PRACTITIONERS, AGENCIES AND EDUCATION PROGRAMS

Section 1. **Authority.** The Department adopts these rules under W.S. § 33-36-103 and W.S. § 35-1-804 to enhance the comprehensive Emergency Medical Services (EMS) and trauma system by establishing criteria for the establishment and operation of Community EMS Programs.

WHAT'S CONTAINED IN THE RULES?

1. **Individuals** are endorsed at one of two levels:
    1. Community EMS Technician (40 hours didactic/40 hours lab/clinical)
    2. Community EMS Clinician
2. **Agencies** require approval to provide the services.
    - At either the Technician or Clinician level.
3. **Education** programs require approval.
    - At either the Technician or Clinician level

1. General Requirements
    A. Specific requirements
        i. Clarification
2. "Stand alone" or General Sections

FOUR LICENSURE LEVELS: TWO LEVELS OF ENDORSEMENT

Section 3. **Endorsement**.

(a) A currently licensed EMT, AEMT, IEMT or Paramedic, may apply for endorsement as a Community EMS Technician or Community EMS Clinician.

(b) Applications for endorsement must contain a verifiable copy of a transcript showing the successful completion of the appropriate Division-approved Community EMS Education Program as described in section 3 of this chapter.

(c) The Division may deny endorsement to any person who submits incomplete or inaccurate information on an application. Fraudulent information shall also be cause for denial, revocation or suspension of the person's EMT, AEMT, IEMT, or Paramedic license.

(d) A person may not hold himself out to be or provide the services of a Community EMS Technician or Community EMS Clinician without endorsement as such by the Division.

(e) An endorsement as a Community EMS Technician or Community EMS Clinician shall expire concurrently with the expiration of the person's EMT, AEMT, IEMT, or Paramedic license.

EDUCATION (DIFFERENCES)

TECHNICIAN

- May be taught by CoAEMSP accredited institution
- Minimum 40 hours didactic
- Minimum 40 hours clinical/lab
- Ultimately, more limited in scope at the Agency level.
- Focused on reducing the burden on the 911/emergency care system

CLINICIAN

- ***Must*** be taught through a college or university
- Minimum of 114 hours didactic
- Minimum of 200 hours clinical in primary or public health setting
- Much broader in scope than the Technician level.
- May incorporate Technician activities into the overall program.

EDUCATIONAL PROGRAMS: GENERAL REQUIREMENTS

Section 4. **Approved Educational Programs.**

(a) The Division may approve a Community EMS Education Program that:

(i) Submits an application for approval to the Division;

(ii) Is conducted by:

(A) A college or university;

(B) An educational institution that has an articulation agreement with a college or university; or

(C) An educational program accredited by the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP), in which case approval shall only be for Community EMS Technician courses;

(iii) Tests student proficiency and periodically measures student learning;

EDUCATION PROGRAMS: SPECIFIC REQUIREMENTS

(c) Community EMS Clinician education programs must provide:

(i) A minimum of one hundred fourteen (114) hours of didactic training and practical and lab skills covering the following subjects:

(A) The Community EMS Clinician's role in the health care system;

(B) The social determinants of health model;

(C) The role of the Community EMS Clinician in public health and primary care;

(D) Developing cultural competency;

(E) Personal safety and wellness of the Community EMS Clinician; and

(ii) A minimum of two hundred (200) hours of clinical experience, appropriate to the individual's established scope of practice, in a primary or public health care setting which provides instruction in:

DOCUMENTATION AND REPORTING

Section 7. **Documentation and Reporting.**

(a) Community EMS Technician programs shall utilize the electronic patient care reporting system provided by the Division for the documentation of clinical care. It is the responsibility of the individual Community EMS Technician to ensure completion of the patient care report.

(b) Community EMS Clinician programs may utilize locally developed and approved forms or electronic reporting systems for documenting the provision of clinical care. Emergency requests for service must be documented in accordance with the requirements of chapter 4 of these rules.

(c) Community EMS Technician and Clinician programs shall provide reports of patient care activities as periodically required by the Division, in a format approved by the Division.

- **Why?**
  - **State reporting system not structured for CEMS**
  - **Anticipating that reporting/reimbursement process may flow more easily by utilizing an existing EHR**

AGENCY APPROVAL REQUIREMENTS

Section 6. **Agency Approval Requirements.**

(a) EMS Agencies may apply for approval to provide services at one of the following levels:

(i) Community EMS Technician (CET) Agency. The activities of these agencies are directed towards reducing the burden of patients accessing the larger health care system through the emergency medical system. Community EMS Technician Agencies may utilize either Community EMS Technicians or Community EMS Clinicians to perform the following activities:

(ii) Community EMS Clinician (CEC) Agency. The activities of these programs are directed toward the integration of EMS personnel in addressing specific gaps in a community's primary and public health care systems, and may incorporate the activities of a Community EMS Technician program. Community EMS Clinician Agencies may utilize Community EMS Clinicians for the purpose of integrating EMS personnel in addressing specific gaps in a community's primary and public health care systems. Community EMS Clinician Agencies may also utilize either Community EMS Technicians or Clinicians for activities listed in section 5(a)(i).

AGENCY REQUIREMENTS

(b) Prior to initiation of operations as a Community EMS Agency, proposals for programs shall be submitted to the Division for approval. Proposals shall contain and describe:

(i) The area and population to be served;

(ii) The conclusions or recommendations of a healthcare gap assessment in the area and population;

(iii) The healthcare goals and objectives;

(iv) The benchmarks and performance measures that will be utilized to measure the efficacy of the program;

(v) The treatment protocols intended to meet the healthcare goals and objectives;

(vi) The name and contact information of the Physician Medical Director providing clinical oversight to the program;

- **Why?**
  - **Require a gap assessment**
  - **Require the programs to demonstrate success**

SCOPE OF PRACTICE (STAND-ALONE)

Section 5. **Community EMS Technician and Community EMS Clinician Scope of Practice and Authority.**

(a) The authorized acts and scope of practice for a Community EMS Technician or Community EMS Clinician are limited to those skills listed for the individual's EMS license level as described in chapter 5 of these rules, and may only be exercised in accordance with protocols or standing orders approved by the Physician Medical Director of the Community EMS Agency.

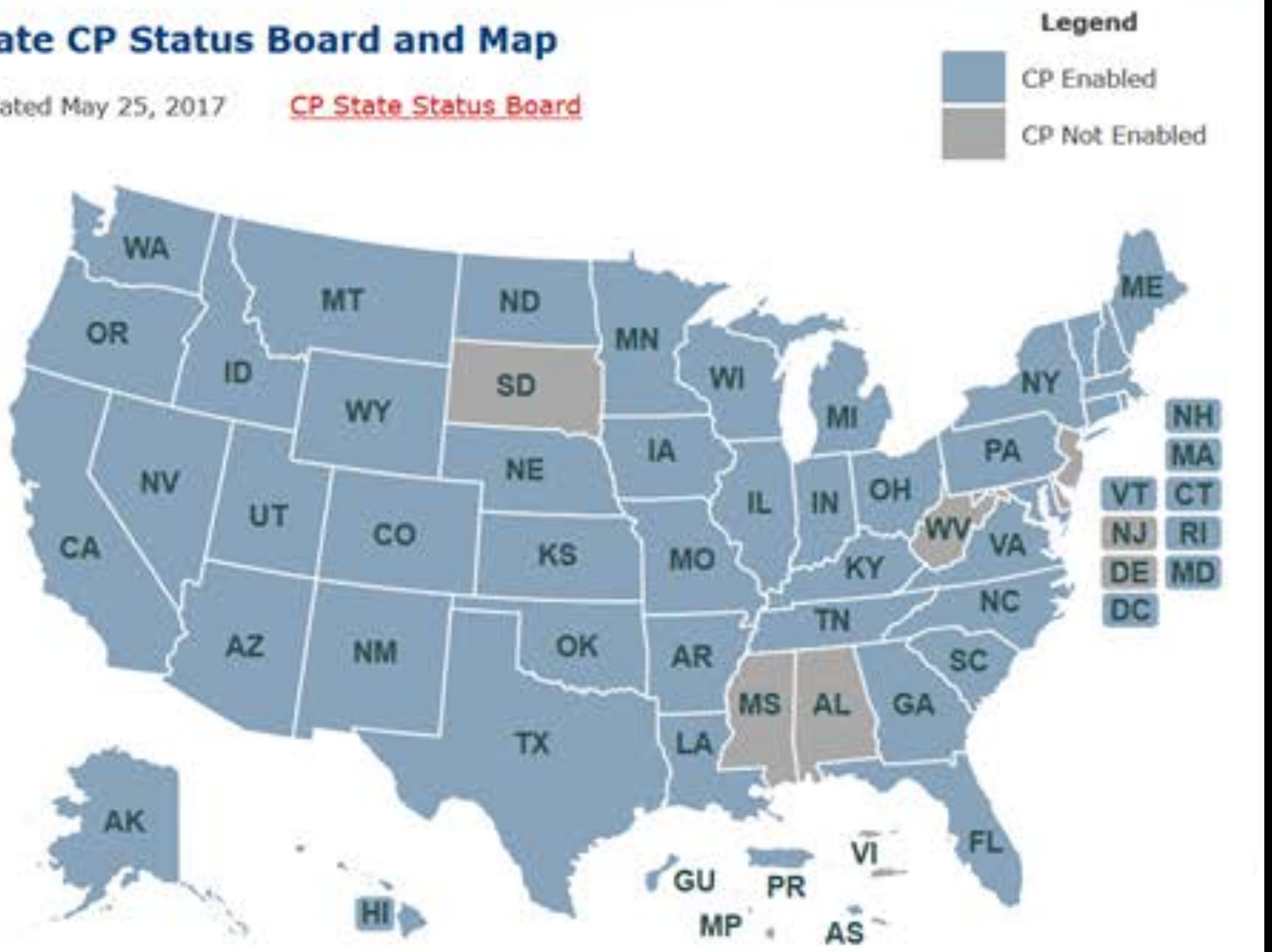
- **Why?**
  - **Not sure what new skills/areas were needed, so hold in place**
  - **Removes ambiguity**

CP Enabled (48 or 86%)	CP Enabled (48 or 86%)	CP Not Enabled (7 or 12%)
Alaska	*Montana	Alabama
*American Samoa	Nebraska	Delaware
Arizona	Nevada	Mississippi
*Arkansas	*New Hampshire	New Jersey
California	*New Mexico	Northern Marianas
*Colorado	*New York	South Dakota
*Connecticut	*North Carolina	Virgin Islands
Florida	+*North Dakota	
Georgia	*Ohio	
*Guam	*Oklahoma	**Unknown (1 or 2%)**
Hawaii	Oregon	Puerto Rico
*Idaho	*Pennsylvania	
Illinois	*Rhode Island	
*Indiana	South Carolina	
Iowa	*Tennessee	
Kansas	Texas	
Kentucky	Utah	
Louisiana	*Virginia	
+*Maine	Vermont	
Maryland	*Washington	
*Massachusetts	*West Virginia	
Michigan	*Wisconsin	
+Minnesota	+*Wyoming	
*Missouri		

*Completed or Anticipated Law/Rule Change in 2015/16 + Medicaid Revenue Secured /Attempt

State CP Status Board and Map

Updated May 25, 2017 CP State Status Board



- Currently No Universal Funding Provisions
  - Start-ups:
    - Self-funded; Excess Capacity
    - Grants
  - Medicaid Policy Evolution
    - Tx/No Transport: e.g. ME, MN, AZ, MI, NV, UT, NC, WI
    - CP Services: e.g. MN, AZ, NV
  - Health Systems/ACOs: e.g. TX
  - Third Party Payors: e.g. MI, KY

PART 440—SERVICES: GENERAL PROVISIONS

■ 35. **Section 440.130** is amended by revising paragraph (c) to read as follows:

§ **440.130 Diagnostic, screening, preventive, and rehabilitative services**.

* * * * *

(c) Preventive services means services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to—

(1) Prevent disease, disability, and other health conditions or their progression;

(2) Prolong life; and

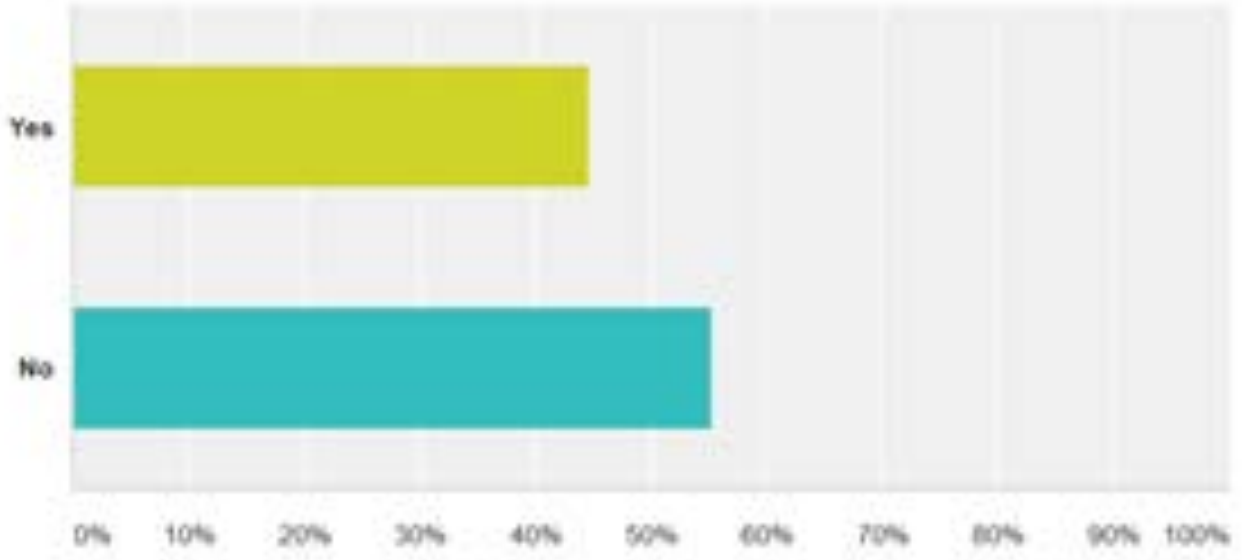
(3) Promote physical and mental health and efficiency.

- Assessment Conducted September, 2014 to April, 2015
- 49/56 States and Territories Responded (88%)
- 45/49 States/Territories have CP activity (92%)

Q6

Is there activity to try to use Medicaid to reimburse CP-MIH services?

Answered: 47 Skipped: 2

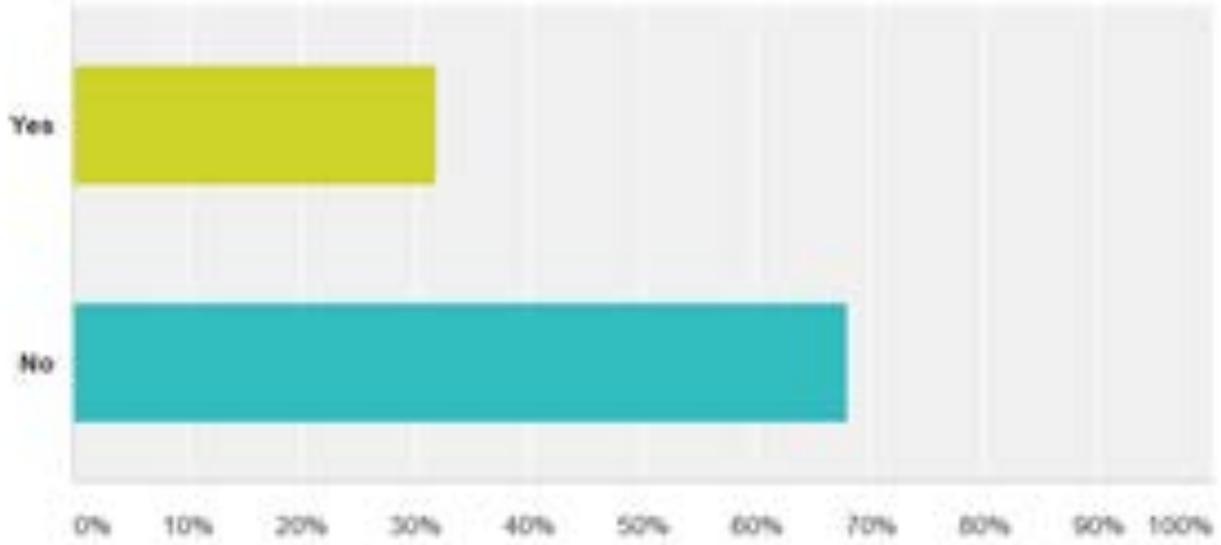


Answer Choices	Responses	
Yes	**44.68%**	21
No	**55.32%**	26
Total		47

Q7

Are third party payers involved in development of CP-MIH reimbursement strategies?

Answered: 47 Skipped: 2

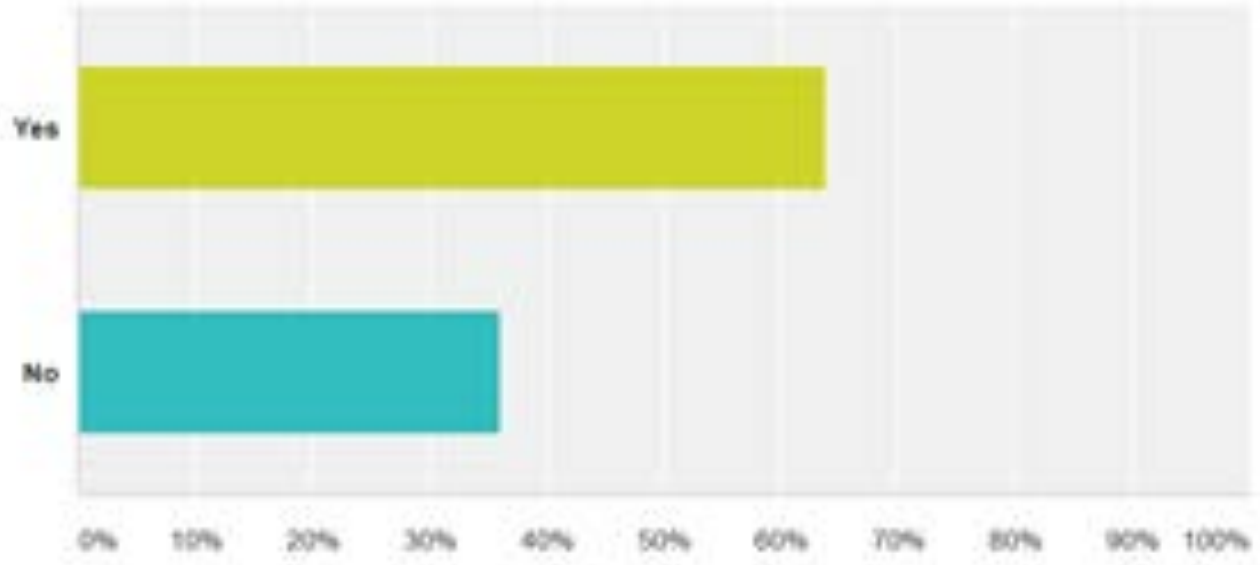


Answer Choices	Responses	
Yes	**31.91%**	15
No	**68.09%**	32
Total		47

Q8

Are hospitals/health systems involved in development of CP-MIH reimbursement strategies?

Answered: 47 Skipped: 2

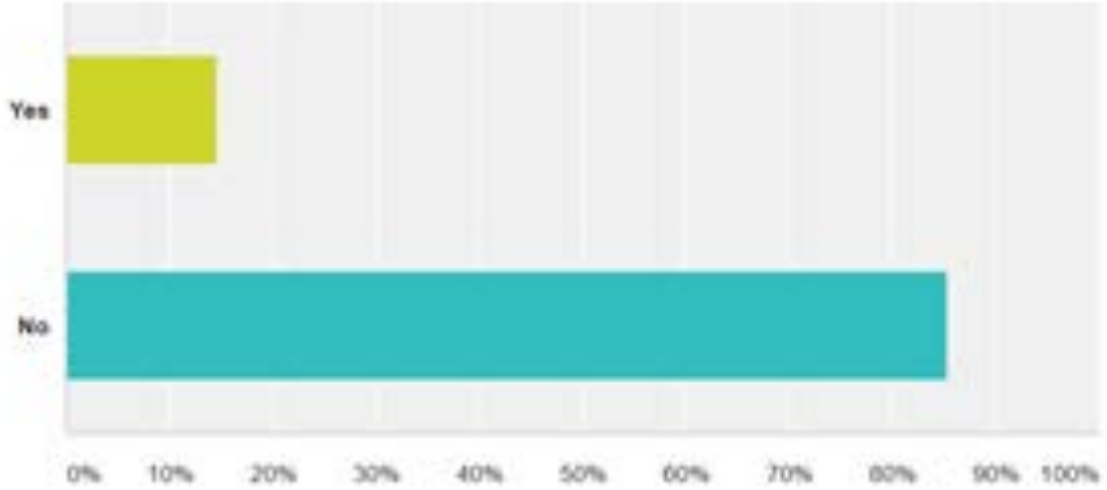


Answer Choices	Responses	
Yes	**63.83%**	30
No	**36.17%**	17
Total		47

Q12

Has your enabling statute or regulations been amended to enable or prohibit community paramedicine to be practiced in the State?

Answered: 48 Skipped: 1

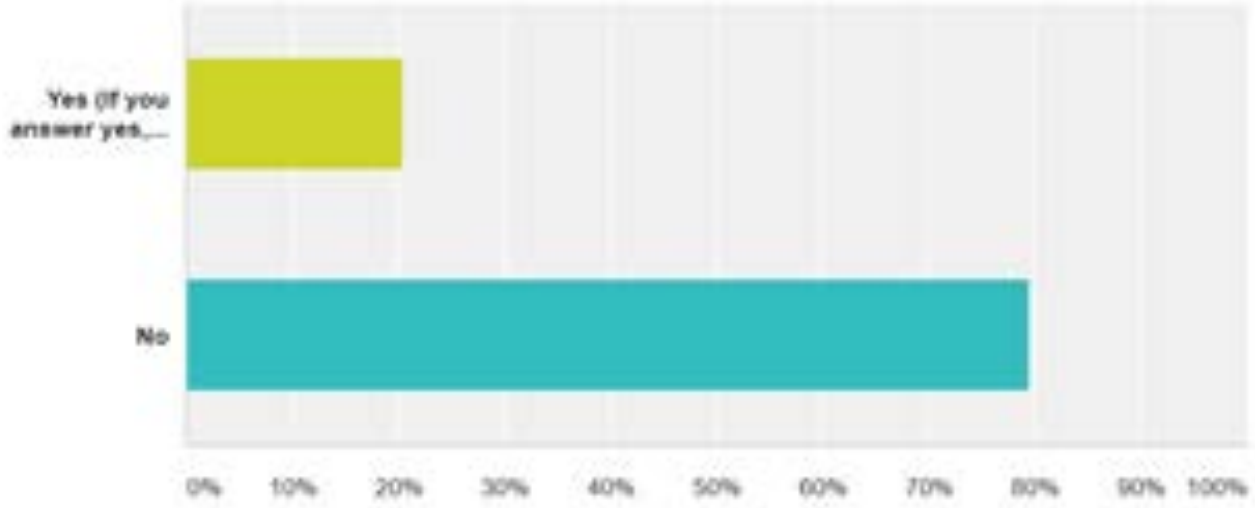


Answer Choices	Responses	
Yes	**14.58%**	7
No	**85.42%**	41
Total		48

Q13

Do you have, or soon expect have, regulations governing education, practice, or other elements specific to CP-MIH?

Answered: 49 Skipped: 0



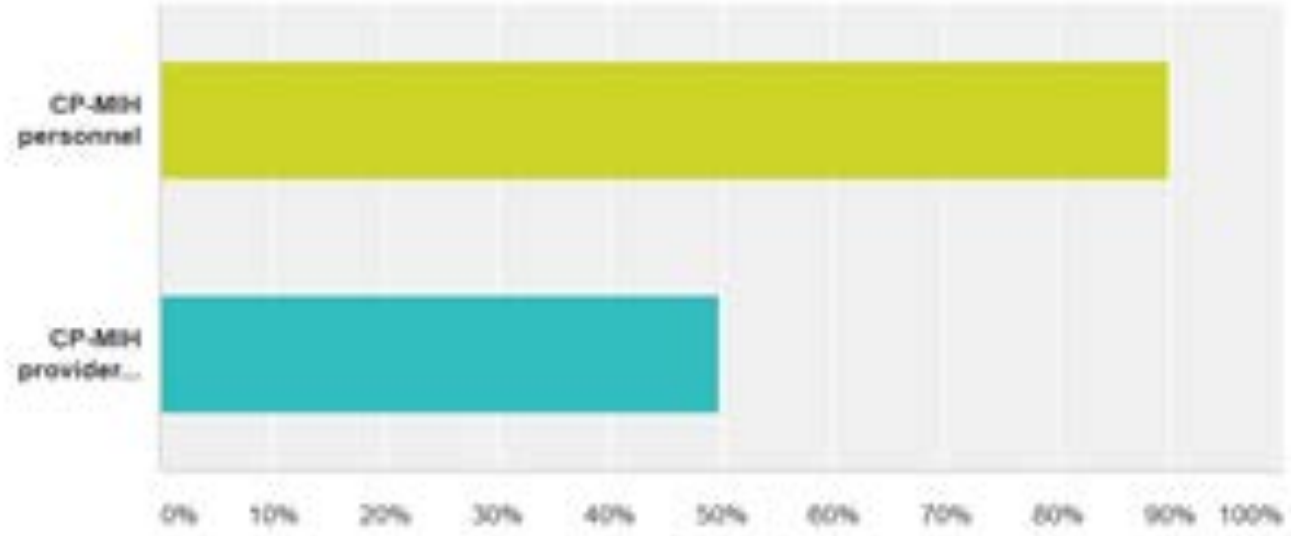
Answer Choices	Responses	
Yes (If you answer yes, please share a link to your regulations in the box below:)	20.41%	10
No	79.59%	39
Total		49

Comments (11)

Q14

Do you, or do you expect to, formally certify/license? (Please check ALL that apply.)

Answered: 20 Skipped: 29

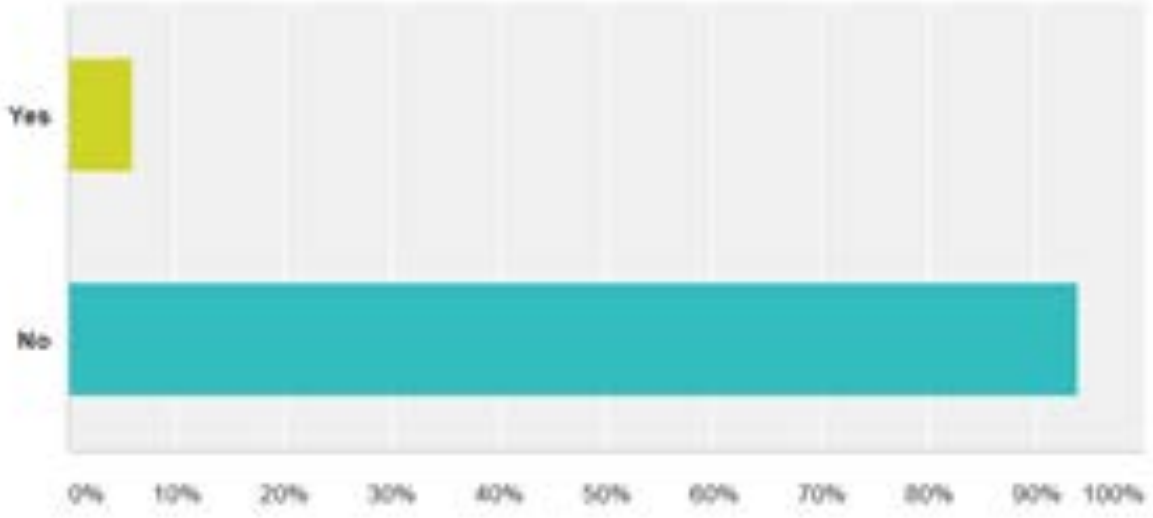


Answer Choices	Responses	
CP-MH personnel	90.00%	18
CP-MH provider agencies	50.00%	10
Total Respondents: 20		

Q15

Do you have regulations with a scope beyond your state's current EMS scope of practice definitions?

Answered: 49 Skipped: 0

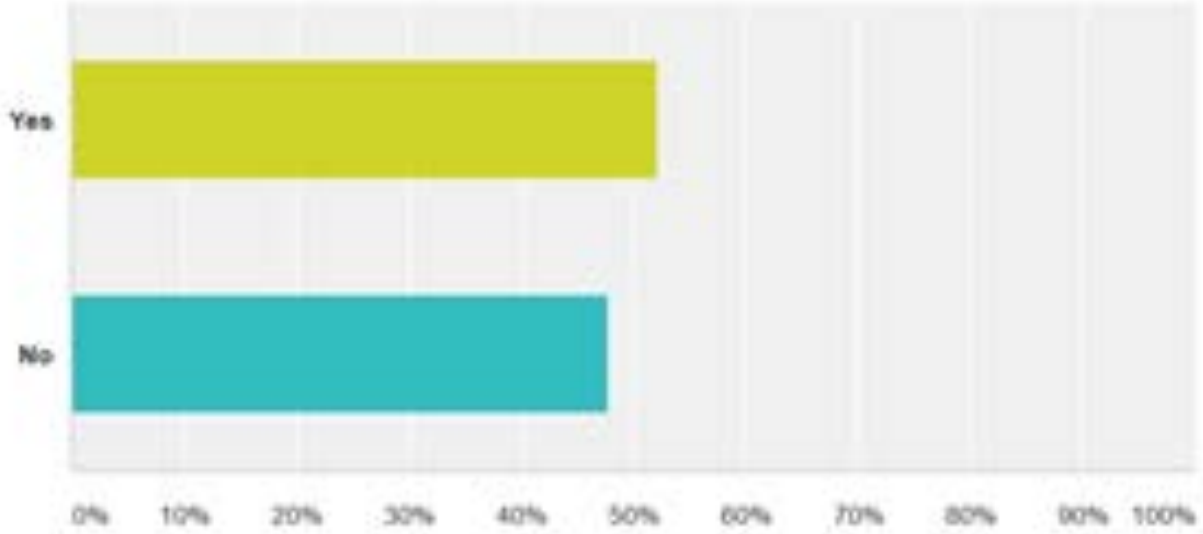


Answer Choices	Responses	
Yes	**6.12%**	3
No	**93.88%**	46
Total		49

Q16

Are agencies that provide CP-MIH services required to have medical directors specifically for that activity?

Answered: 46 Skipped: 3

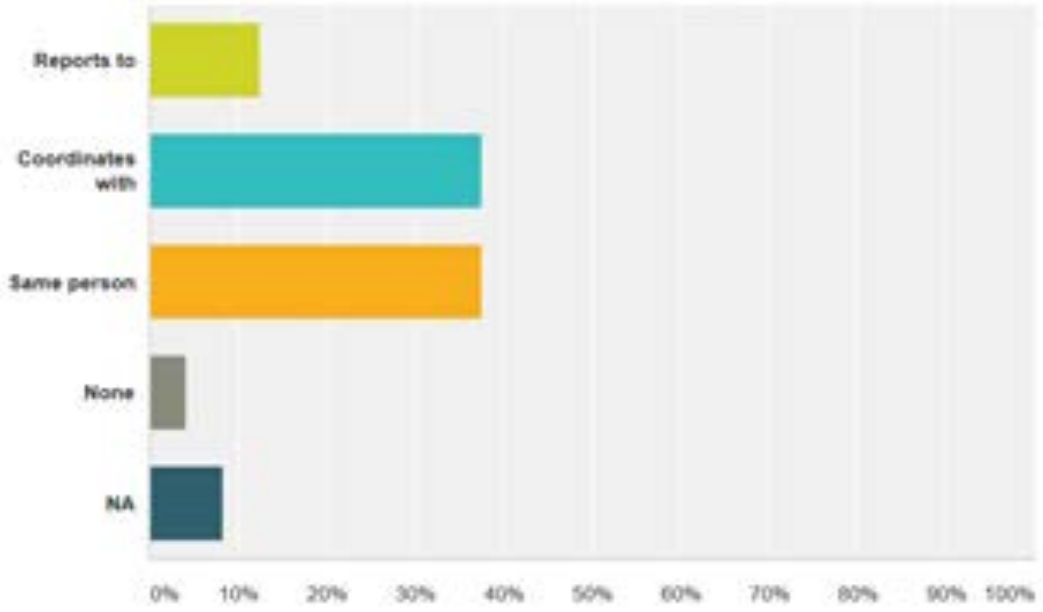


Answer Choices	Responses	
Yes	**52.17%**	24
No	**47.83%**	22
Total		46

Q20

If yes, what is the relationship with the EMS medical director?

Answered: 24 Skipped: 25

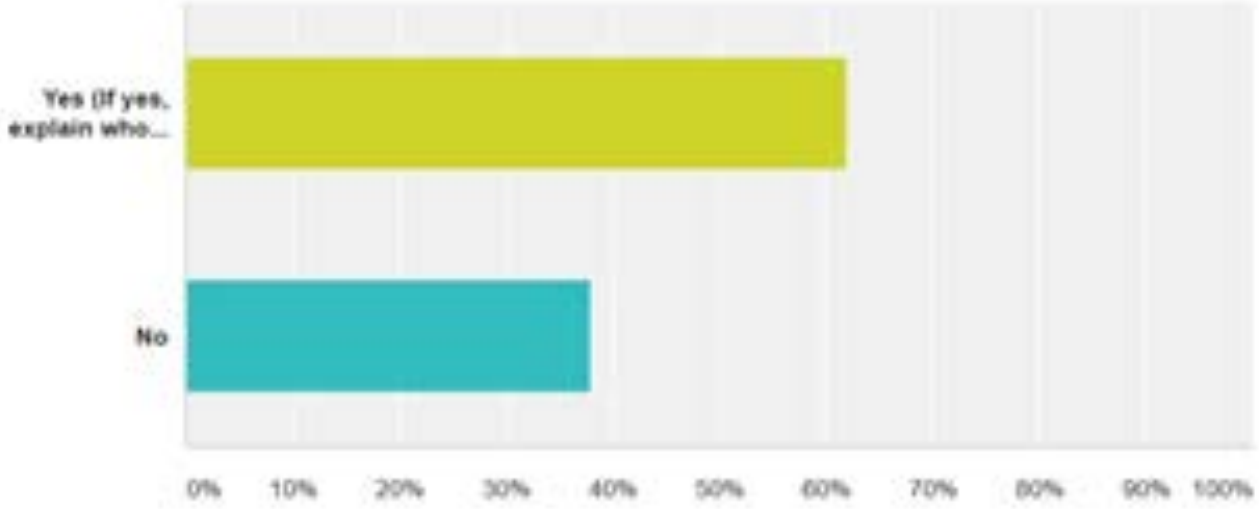


Answer Choices	Responses	
Reports to	12.50%	3
Coordinates with	37.50%	9
Same person	37.50%	9
None	4.17%	1
NA	8.33%	2
Total		24

Q21

Is on-line medical direction commonly available for CP-MIH activities?

Answered: 42 Skipped: 7



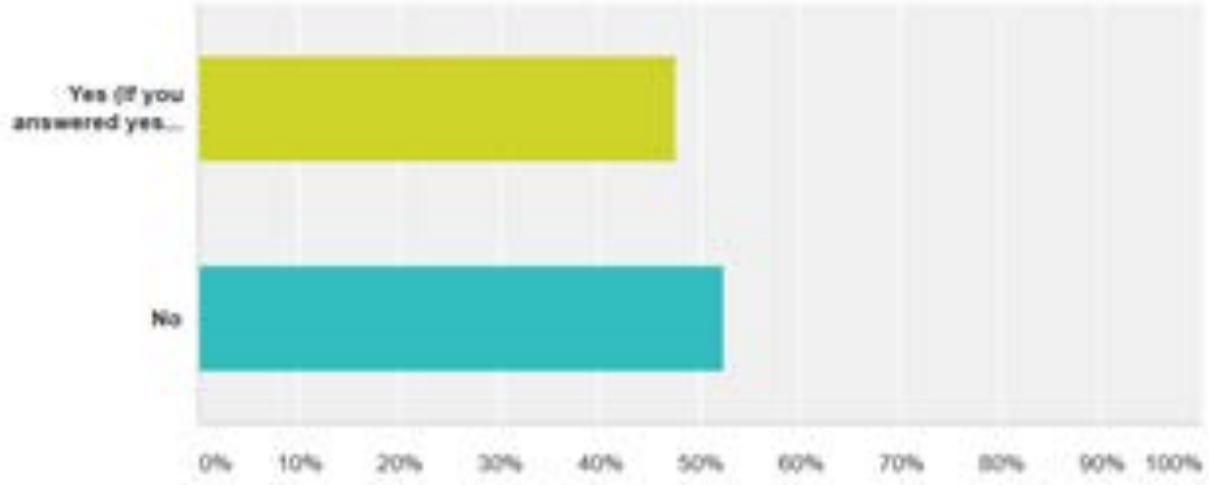
Answer Choices	Responses	
Yes (If yes, explain who provides this medical direction in the box below.)	61.90%	26
No	38.10%	16
Total		42

Comments (25)

Q22

Are standing orders commonly used for CP-MIH?

Answered: 40 Skipped: 9



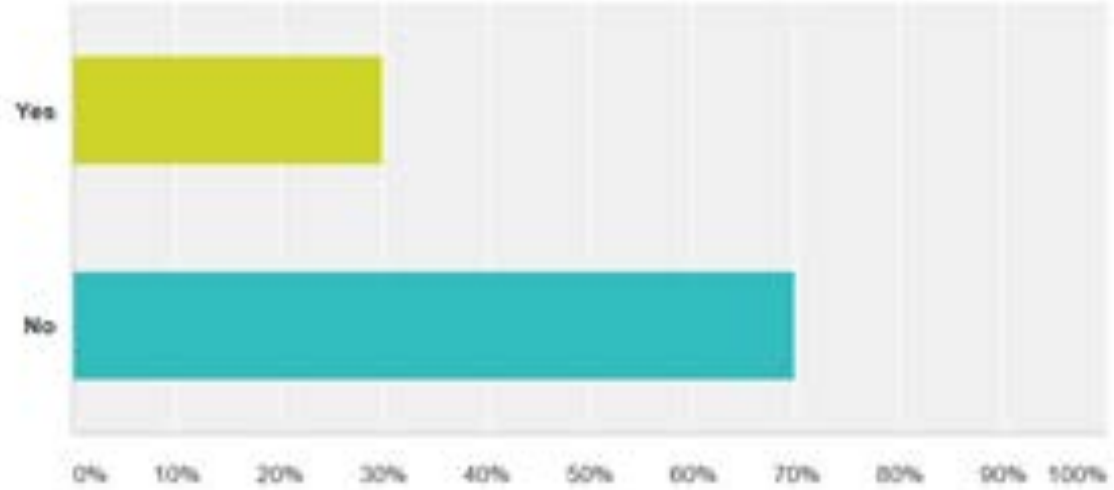
Answer Choices	Responses
Yes (If you answered yes, please explain who develops these standing orders in the box below.)	47.50% 19
No	52.50% 21
Total	40

Comments (22)

Q23

Are CP-MIH services required to do (or access an existing) community health needs assessment before commencing services?

Answered: 40 Skipped: 8

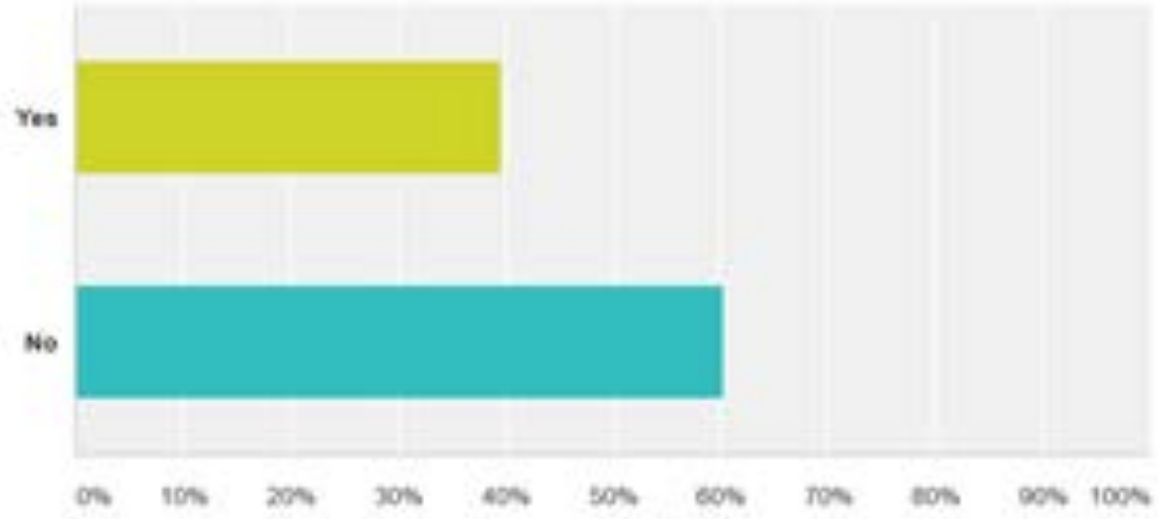


Answer Choices	Responses	
Yes	30.00%	12
No	70.00%	28
Total		40

Q27

Have you adopted, or do you soon plan to adopt, a CP-MIH evaluation plan at the state level?

Answered: 48 Skipped: 1

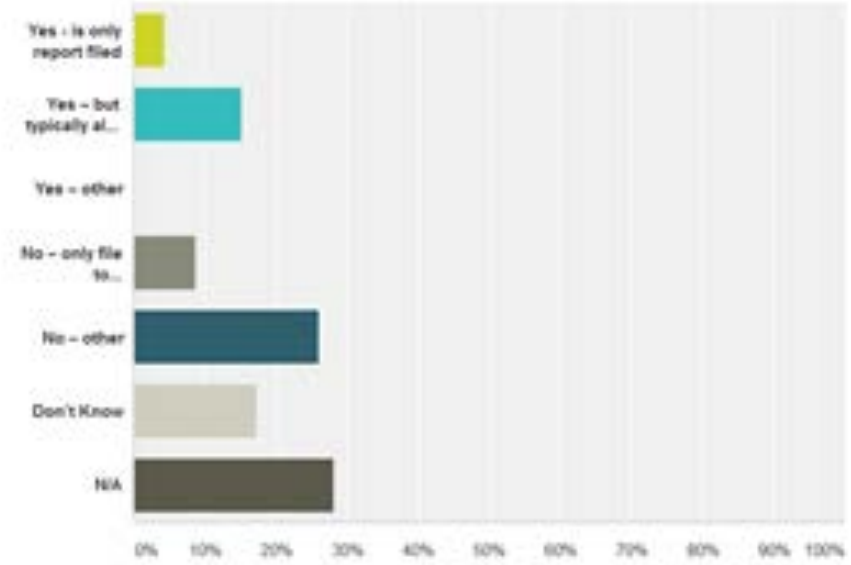


Answer Choices	Responses	
Yes	**39.58%**	19
No	**60.42%**	29
Total		48

Q31

Do CP-MIH provider agencies use the state EMS data collection system for CP-MIH patient record entry?

Answered: 46 Skipped: 3



Answer Choices	Responses	
Yes - is only report filed	4.35%	2
Yes – but typically also file separate report to hospital/health system, physician practice, or regional electronic record system	15.22%	7
Yes – other	0.00%	0
No – only file to hospital/health system, physician practice, or regional electronic record system	8.70%	4
No – other	26.09%	12
Don't Know	17.39%	8
N/A	28.26%	13
Total		46

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