National Association of State EMS Officials

EMS Office Assessment of the Status of Community Paramedicine/Mobile Integrated Healthcare in the States and Territories

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Executive Summary

Community paramedicine (CP) first emerged as a formal concept in 2001, though EMS personnel previously serving in other than emergency response roles in many places for many years was documented in the *Rural and Frontier EMS Agenda for the Future* (*Agenda*) in 2004.

The *Agenda's* aftermath was marked with an acceleration of CP start-ups, particularly evident in the past five years as the health care system and its priorities have rapidly evolved. Increasingly, state and territorial EMS offices have been involved in leadership and regulatory aspects of CP system and service development. The purpose of this report is to assess that progress and its impact.

Forty-nine of 56 states and territories (88%) responded to this Fall 2014 to Spring 2015 survey. Only five EMS offices reported no known CP related activity in their states. Just ten (20%) EMS offices reported having no agencies actively planning or providing some form of CP service. Another ten EMS offices reported services in the planning/development stages, and the remaining 29 (60%) had between one and twenty-five agencies offering CP type services.

Twenty-seven state offices (55%) interpret their laws as enabling or not prohibiting CP practices. Between a quarter and third have made no interpretations. Another eight states expect to have legislation in the next three years to enable CP.

Reimbursement of CP practices remains a challenge. Sixty-four per cent (30 offices) reported that hospitals or health systems are involved in developing reimbursement for CP, however the same number and percentage of states reported that there is no statewide strategy for reimbursement. Fifty-five per cent (26 states) reported activity in trying to achieve reimbursement for Medicaid patients.

The report provides some enlightenment, though no particular trends, about state EMS office resources for CP planning, and about needs assessment activity, medical direction and performance measurement for CP programs.

Data collection and data communication tools for the practice of CP remain a problem. The electronic EMS patient record tools available today were not designed for CP practice, and do not integrate well beyond state EMS data systems. This leaves CP agencies to design their own charting tools which communicate with their partnering physician and other practices, clinics and services, hospitals, payers, and health information exchanges. This often means that CP providers must complete at least two records for each patient interaction.

Introduction

Community paramedicine (CP) first emerged as a formal concept in 2001, though EMS personnel serving in other than emergency response roles was a not-uncommon occurrence particularly in rural communities. The Red River, New Mexico program had EMS personnel providing primary care out of a firehouse in the 1990's, and EMS personnel serving rural health centers and hospitals between calls going back many years was documented in the *Rural and Frontier EMS Agenda for the Future* (*Agenda*) in 2004. These practices simply had no particular identity before 2001.

Subsequent to publication of the *Agenda,* CP began to appear in Canada and then throughout United States, with an acceleration of start-ups evident in the past five years. Increasingly, state and territorial EMS offices have been involved in leadership and regulatory aspects of CP system and service development. The purpose of this report is to assess that progress and its impact.

Beginning in the fall of 2014 and through the spring of 2015, state and territorial EMS officials responded to a survey conducted by the National Association of State EMS Officials (NASEMSO). Forty-nine of 56 states and territories (88%) responded to the survey. At least two states chose not to respond because of the political sensitivity of the subject.

More recently, the term "mobile integrated healthcare" has found use for practices similar to community paramedicine. This is generally an administrative construct of practice relationships among independent providers for the purpose of navigating patients to an appropriate type and level of care. The significance of the differences in the nomenclature involved is being discussed on the national level by leaders in this area. For the purpose of this report, and as specified to respondents to the survey, these terms are used interchangeably and called "Community Paramedicine – Mobile Integrated Healthcare" or CP-MIH.

In this report, respondents are called "states". That is intended to include commonwealths and territories. State by state status reports were gathered over a seven month period, while activities in each state have continued to evolve. This information will serve as a first installment on the NASEMSO website of an ongoing status report of such projects which will be regularly updated.

Results

States and Territories That Responded

Of 56 states and territories, the following 49 (88%) responded to the survey:

Alabama	Idaho	Nebraska	South Carolina
Alaska	Indiana	Nevada	South Dakota
American Samoa	Iowa	New Hampshire	Tennessee
Arizona	Kansas	New Jersey	Texas
Arkansas	Kentucky	New Mexico	Utah
California	Louisiana	New York	Vermont
Colorado	Maine	North Carolina	Virginia
Connecticut	Maryland	North Dakota	Washington
Delaware	Michigan	Northern Marianas Islands	Wisconsin
Florida	Minnesota	Ohio	Wyoming
Georgia	Mississippi	Oklahoma	
Guam	Missouri	Pennsylvania	
Hawaii	Montana	Rhode Island	

States and Territories Reporting CP-MIH Planning and Development Activities

Forty-eight of 49 offices responded to a question asking about the extent of CP-MIH planning and development activities experienced to date, with only five reporting no activities in this regard. Of those reporting that activities exist, some characterized them as preliminary "discussions", others as well-formed local programs, while some reported state-recognized or state-sponsored pilot programs (Maine, California, Arkansas, Ohio, Missouri, and Michigan).

Again, the following state by state status reports were gathered over a seven month period, while activities in each state have continued to evolve. This information will serve as a first installment on the NASEMSO website of an ongoing status report of such projects which will be regularly updated. The individual state responses included:

- **Alaska**: "We currently have the original model for integrated health care which is our community health aide program. Community Health Aide Program members get EMT training and provide coverage in clinics with physician involvement. This is a very robust program with funding. The new model of paramedic involvement is being considered but has statutory issues. We also have dental aides in a similar model."
- **American Samoa**: "A needs assessment and report was provided to AS EMS, hospital, public health and legislature. In a follow-up visit, a strategic plan was developed to guide the implementation of CP in the territory."
- **Arizona**: "Department of Health sponsored Community Integrated Paramedicine (CIP) work group met over a 9-month period to characterize existing AZ/CIP programs and to identify resources. A resource document is being developed as a result of the meeting. Spontaneous CP/MIH programs initiation continues, chiefly in the fire-based organizations."
- **Arkansas**: "We are currently looking at enabling legislation for CP-MIH. We currently have one pilot program providing CP-MIH Care."

- **California**: “The California EMS Authority is in the final approval process with the State Office of Healthcare Planning and Development to conduct a Community Paramedicine Pilot Project in 12 sites throughout California. We expect final approval by November 12, 2014.”
- **Colorado**: “Local development of CP-MIH services. Several EMS agencies are doing some form of CP-MIH activities. A couple of agencies have received a home care license from the state health department to operate their programs; others are doing activities without any state involvement.”
- **Connecticut**: “Educational initiative (summit) to develop further understanding of the CP-MIH concept among stakeholders.”
- **Georgia**: “The Georgia Association of EMS has received a grant from the Georgia Office of Rural Health to study CP-MIH. Awaiting the final report.”
- **Guam**: “Interagency meetings with Guam Fire Department, Guam Community College, and EMS Commission members to include private ambulance and EMS providers, EMS Medical Director, and Guam EMS Office, as well as military partners.”
- **Hawaii**: “Research and active discussions are being done, focusing on State contracted EMS services collaborating with Federally Qualified Health Centers in rural and suburban areas. This includes the concept of a shared call-intake center that would identify CP-MIH services from 911 services.”
- **Idaho**: “Community Health EMS subcommittee has been added to our state EMS Advisory Committee to encourage the development of MIH/CP programs and share best practices. CP/MIH has been discussed as a viable solution to health care challenges in Idaho during the State Health Innovation Plan (SHIP) project. The EMS Bureau and the state Office of Rural Health collaborate on the development of CP programs in rural areas of the state.”
- **Indiana**: “Currently our agency has assembled a committee to review the different components of establishing CP-MIH in Indiana. We have reviewed the necessary stakeholders and will be holding an informational session in December, 2014 to review current programs, curriculum, and possible legislation needed.”
- **Iowa**: “Initial planning meetings.”
- **Kansas**: “Currently, we have one of our EMS associations pursuing the planning and development of a statewide CP-MIH plan.”
- **Kentucky**: We have developed a Community Paramedicine Handbook in Kentucky for services to use as a reference.
- **Louisiana**: “We have various CP-MIH programs developing across Louisiana. All of these programs are still at a certificate level as an addendum to the Paramedic license. We are developing a Master's prepared Advanced Practice Paramedic as a mid-level practitioner dedicated for "EMS".
- **Maine**: “Twelve pilot projects have been approved in Maine and are seeing patients. Evaluation of CP pilots will be taking place over the next 6-9 months.”
- **Maryland**: “Has a unique healthcare economy: the state has signed on for the Affordable Care Act and recently renegotiated an agreement with the Centers for Medicare and Medicaid Service (CMS) that would change hospital reimbursement from Fee for Services to Pay for Performance. This is creating pressure for hospitals to form partnerships with EMS and public health. There is one pilot program in one jurisdiction and much discussion about grants to fund additional projects.”
- **Michigan**: “Approved one CP program to begin in May, 2014. Several other agencies have applied to begin programs which are currently under review with anticipated approval.”

- **Minnesota**: “Has specific laws for certification of Community Paramedics and specific provisions the Community Paramedic must work under. The certification requirements, practice requirements and certification renewal requirements are cited from Minnesota Statute section 144E.28, subd.9 and subd.60:
    - Subd. 9. Community paramedics. (a) To be eligible for certification by the board as a community paramedic, an individual shall: (1) be currently certified as a paramedic and have two years of full-time service as a paramedic or its part-time equivalent; (2) successfully complete a community paramedic education program from a college or university that has been approved by the board or accredited by a board-approved national accreditation organization. The education program must include clinical experience that is provided under the supervision of an ambulance medical director, advanced practice registered nurse, physician assistant, or public health nurse operating under the direct authority of a local unit of government; and (3) complete a board-approved application form. (b) A community paramedic must practice in accordance with protocols and supervisory standards established by an ambulance service medical director in accordance with section 144E.265. A community paramedic may provide services as directed by a patient care plan if the plan has been developed by the patient's primary physician or by an advanced practice registered nurse or a physician assistant, in conjunction with the ambulance service medical director and relevant local health care providers. The care plan must ensure that the services provided by the community paramedic are consistent with the services offered by the patient's health care home, if one exists, that the patient receives the necessary services, and that there is no duplication of services to the patient. (c) A community paramedic is subject to all certification, disciplinary, complaint, renewal, and other regulatory requirements that apply to paramedics under this chapter. In addition to the renewal requirements in subdivision 7, a community paramedic must complete an additional 12 hours of continuing education in clinical topics approved by the ambulance service medical director. Minnesota has statutory language for payment for services by Community Paramedics. Minnesota Statutes, section 256B.0625,
    - Subd. 60. Community paramedic services. (a) Medical assistance covers services provided by community paramedics who are certified under section 144E.28, subdivision 9, when the services are provided in accordance with this subdivision to an eligible recipient as defined in paragraph (b). (b) For purposes of this subdivision, an eligible recipient is defined as an individual who has received hospital emergency department services three or more times in a period of four consecutive months in the past 12 months or an individual who has been identified by the individual's primary health care provider for whom community paramedic services identified in paragraph (c) would likely prevent admission to or would allow discharge from a nursing facility; or would likely prevent readmission to a hospital or nursing facility. (c) Payment for services provided by a community paramedic under this subdivision must be a part of a care plan ordered by a primary health care provider in consultation with the medical director of an ambulance service and must be billed by an eligible provider enrolled in medical assistance that employs or contracts with the community paramedic. The care plan must ensure that the services provided by a community paramedic are coordinated with other community health providers and local public health agencies

and that community paramedic services do not duplicate services already provided to the patient, including home health and waiver services. Community paramedic services shall include health assessment, chronic disease monitoring and education, medication compliance, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow-up care, and minor medical procedures approved by the ambulance medical director. (d) Services provided by a community paramedic to an eligible recipient who is also receiving care coordination services must be in consultation with the providers of the recipient's care coordination services. (e) The commissioner shall seek the necessary federal approval to implement this subdivision."

- **Mississippi**: "EMS Functionality Committee developed to explore scope of practice, medical control and fit in current EMS structure in Mississippi."
- **Missouri**: "Legislation has been passed. The Bureau is now promulgating regulations pursuant to the legislation."
- **Montana**: "The state EMS office is engaged with information and educational strategies and we're moving to development of a state plan for implementation of MIH-CP programs. Legislative activity for 2015 is possible but not approved yet."
- **Nebraska**: "We have had two statewide focus groups, and have kept the EMS Board briefed on developments at the state and national level. We passed legislation two years ago allowing providers to practice within their scope of practice to provide patient care in a non-emergency setting."
- **Nevada**: "We currently have EMS agencies practicing CP-MIH; they are all working under current scope of practice. We may have legislator placing a bill draft request (BDR) for expanded scope and possible alternate transport within the state."
- **New Hampshire**: "Implementing a statewide pilot project based on Maine's model. We are exempting EMS from our homecare rules for a period of three years to study the delivery models."
- **New Mexico**: "Community EMS Coalition - Monthly meeting of stakeholders, including EMS agencies, educational entities, legislator, and NM Department of Health (DOH) EMS Bureau. Internal planning and concept discussions at NM DOH."
- **New York**: "The activities range from attempts toward statutory change, demonstration programs, and training curricula."
- **North Carolina**: "Office of EMS has established a work group (current CP/MIH programs, medical directors, state medical director, shareholders and stakeholders) to look at the sustainability of CP/MIH in North Carolina. The North Carolina Office of EMS has established an Education Sub-Committee to develop the minimum requirements needed for CP/MIH education in North Carolina."
- **North Dakota**: "In 2013, the North Dakota Legislature passed legislation authorizing the Department of Health to conduct a pilot Community Paramedic program. A subcommittee of the ND EMS Advisory Board was formed to begin initial planning. A half time coordinator was hired in late 2013 to oversee the program. There are four EMS agencies who have submitted proposals and are currently training staff. Two additional agencies have proposals that are pending approval. We have begun administrative rulemaking to create a licensure level for Community Paramedics."
- **Ohio**: "The Ohio Revised Code currently restricts certificate holders to provision of emergency medical services. The State Board of Emergency Medical, Fire, and Transportation Services has established an Ad Hoc Committee. The Committee has drafted a white paper and is working with a stakeholder group to draft enabling legislation."

- **Oklahoma**: “Discussions.”
- **Pennsylvania**: “Several programs are at work in the state. We get at least monthly inquiries to our office. Our statewide advisory council has a standing committee that is tasked with the information flow and recommendations regarding these programs.
- **Rhode Island**: “We have convened a work group with agencies interested in CP-MIH and are developing draft regulations to address potential regulatory issues.”
- **South Carolina**: We are currently conducting a single-service CP pilot program which we will be expanding to a state-wide pilot CP program.
- **South Dakota**: “Some, however medical board states this is illegal & are against it. Until views are changed & legislation passed, this will not happen in SD.”
- **Tennessee**: “We have a multi-disciplinary committee which is meeting monthly. The committee is developing and completing surveys. The committee is developing educational competencies to be adopted statewide. They are also recommending criteria for state rules for endorsement on Paramedic license for Community Paramedic. The committee is also working on strategies to overcome reimbursement issues. Our committee members represent multiple disciplines.”
- **Utah**: “At the State EMS Bureau, we have been planning and collaborating with agencies in our state concerning the CP-MIH program.”
- **Vermont**: “Injury prevention work funded by Federal Administration for Community Living/Administration on Aging (ACL/AOA).”
- **Virginia**: “Met with the Office of the Attorney General and the Virginia Department of Health Office of Licensure and Certification and established that EMS agencies must hold a Home Care Organization license to offer this service. See memorandum: http://www.vdh.virginia.gov/OEMS/NewsFeatures/GuidanceDocument-MoblieIntegratedHealthcare.pdf.”
- **Washington**: “A lot of discussion and the WA State Fire Chiefs are sponsoring a summit with primary focus on this in November, 2014.”
- **Wisconsin**: “There are some planning and development activities around well patient checks.”
- **Wyoming**: “Hosted a statewide stakeholder meeting. Multiple agencies are considering implementing programs, but none are currently operational to our knowledge.”

Provide a List of Local Services Providing CP-MIH

All forty-nine respondents replied, with ten (20%) reporting no services known to be providing CP-MIH. Ten respondents report services planning/pursuing interest in CP-MIH (20%), and the remainder (60%) report at least one service providing CP-MIH with one state reporting approximately 25 services doing so.

- **Alaska**: “Anchorage, Valdez, and many others are in planning stages.”
- **American Samoa**: “Only has one EMS service and they are planning to be engaged with CP.
- **Arkansas**: Baxter Regional Medical Center (Pilot Program).”
- **California**: “Solano, Alameda, Mountain Valley, Los Angeles, San Diego, San Bernardino, Ventura, Santa Barbara, Butte, Orange Counties.”
- **Colorado**: “Eagle County Paramedic Services, Colorado Springs Fire Department, Pagosa Springs Medical Center, Upper San Juan South Metro Fire Rescue Authority, Ute Pass Regional EMS, Longmont Public Health.”
- **Florida**: “Sunrise Fire Rescue, Commercial Diving Academy Technical Institute, South Walton Fire District, Sanford Fire Department, Highlands County EMS, Ft Myers Beach FD, Martin Health

System, Advanced Medical Transport, Riviera Beach Fire Rescue, Rockledge Fire & Emergency Services, Pinellas County EMS, Century Ambulance Service, Inc., Estero Fire Rescue, Leon County EMS, Polk County Fire Rescue, Escambia County EMS, Atmore Ambulance Inc., Falck (dba American Ambulance of FL), Sarasota County Fire Department, City of Satellite Beach, Okaloosa County Department. of Public Safety, TransCare Medical Transportation."

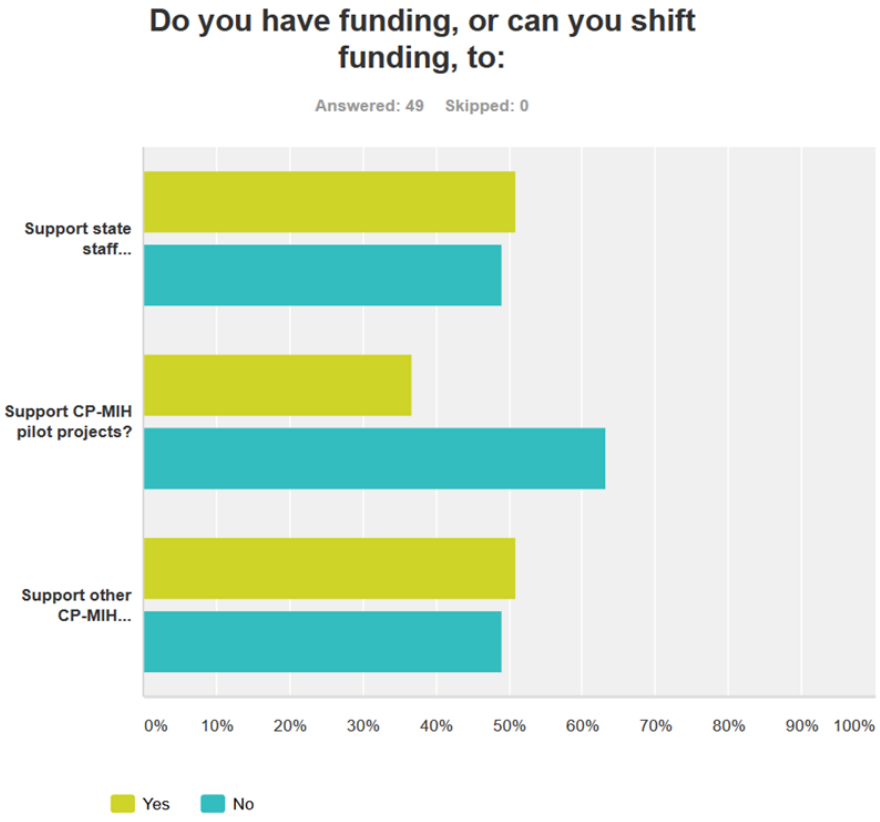
- **Georgia**: "Grady Hospital EMS, Hall County Fire/EMS, Gold Cross EMS, Inc., MetroAtlanta Ambulance, Gwinnett Fire/EMS, Spaulding Regional EMS."
- **Hawaii**: "American Medical Response (AMR) - Kauai and AMR-Oahu are actively involved in the current planning discussions, but no active CP-MIH planning has been implemented."
- **Idaho**: "Ada County Paramedics, Teton County EMS, Moscow Ambulance, Bonner County EMS, Swan Valley Ambulance."
- **Indiana**: "Indianapolis EMS, Fishers Fire Department/Community Hospital, Carmel Fire department, Ball-Memorial Indiana University Hospital, Prompt Medical, Wayne Township Fire Department."
- **Iowa**: "Currently closely working with Iowa Department of Public Health, EMS Association, Training Centers and local agencies."
- **Kansas**: "Olathe Fire Department (offering), Sedgwick County EMS (planning). Depending on the definition of CP-MIH, we may have more services doing this, just not formally (under the auspices of community service)."
- **Kentucky**: "Numerous across our commonwealth (10-20 estimated)."
- **Louisiana**: "Baton Rouge EMS, New Orleans EMS, Shreveport EMS, Acadian Ambulance, Pafford EMS."
- **Maine**: "North East Mobile Health Services, United Ambulance, Delta Ambulance, Winthrop Ambulance, Lincoln County Healthcare (Waldoboro, Central Lincoln County, Boothbay Regional Ambulance), Mayo Hospital Ambulance, CA Dean Hospital, NorthStar EMS, Castine Fire, Searsport EMS, Calais Fire, Crown Ambulance, St. George Ambulance."
- **Maryland**: "Broad-based (healthcare system, public health, nursing, EMS) pilot program approved in Queen Anne's (QA) County. This is a year-long pilot program which is approximately 3/4 completed. It is run by the QA Department of Health, Shore Health (the healthcare entity) and the QA Department of Emergency Services."
- **Michigan**: "Life EMS, in Grand Rapids, is the program which has received State of Michigan approval."
- **Minnesota**: "North Memorial Ambulance Service, Allina Health Medical Transportation, Cuyuna Regional Medical Center, Meds 1 Emergency Medical Services, Hennepin County EMS, (there may be more)."
- **Missouri**: "Two services in the State are actively operating pilot programs."
- **Montana**: "A county/tribal EMS service has trained CPs but is not active yet. A veterans group is close to implementing a mental health/suicide prevention program for vets."
- **Nebraska**: "Valley Ambulance Service Medics At Home. Three hospital based ambulance services are exploring possibly offering services similar to CP-MIH."
- **Nevada**: "REMSA, Humboldt General Hospital EMS, Lander County EMS, Banner Churchill EMS."
- **New Hampshire**: "Unknown at this time. Significant interest."
- **New Mexico**: "City of Santa Fe Fire Department, Albuquerque Fire Department, Albuquerque Ambulance Service, Rio Rancho Fire Department."

- **North Carolina**: “Wake County EMS, New Hanover Regional Medical Center EMS, Cumberland County EMS, Guilford County EMS, McDowell County EMS, Rowan County EMS, Nash County EMS, Lumberton Rescue and EMS.”
- **North Dakota**: “F-M Ambulance Service - Fargo, ND; Rugby EMS - Rugby, ND; Bowman Ambulance Service - Bowman, ND; Billings County EMS - Medora, ND.”
- **Ohio**: “CP services by EMS certificate holders not currently permitted, although areas of the state are laying foundation for future implementation.”
- **Pennsylvania**: “LifeTeam of Harrisburg, Suburban EMS (from Pocono area), Center for Emergency Medicine (in Pittsburgh area).”
- **Rhode Island**:” Cumberland EMS (interested), Providence Fire Department (interested), Coastline EMS (interested).”
- **South Carolina**: Abbeville County EMS is currently online. Many services (over 20) are interested but have not formerly applied yet.
- **South Dakota**: “Some, however medical board states this is illegal & are against it. Until views are changed and legislation passed, this will not happen in SD.”
- **Tennessee**: “None at this time. We plan on having pilot programs approved by the EMS Regulatory Board once all pieces are complete. Interest exists.”
- **Texas**: “We have about 12 that we are aware of, there is no law in Texas that requires the provider to inform the state office as long as their medical director approves.”
- **Utah**: “Salt Lake City Fire Department.”
- **Vermont**: “Various, approximately 25.”
- **Virginia**: “Chesterfield Fire/EMS, Portsmouth Fire/EMS, Galax/Grayson Fire/EMS, Carillion Clinic Patient Transport Services, Lynchburg Fire/EMS, Abingdon Ambulance Service, Alexandria Fire Department Richmond Ambulance Authority, Dickenson County Ambulance Service, Fairfax County Fire/EMS.”
- **Washington**: “A lot of preventive, social services type of work is going on. Pioneer Hospital received an Innovation Grant from CMS. The program is a collaborative effort among the physicians, EMS, home health and hospital discharge planning.”
- **Wisconsin**: “Green Bay Fire Department.”
- **Wyoming**: “Multiple agencies are considering implementing programs, but none are currently operational to our knowledge.”

EMS Office Resources for CP-MIH

Half of the offices report to have access to resources to support staff involvement in CP-MIH development, while a third have resources to support pilot projects (Table 1). Given that offices report in a previous question that only 20% of states are without CP-MIH activity or interest in development, there appears to be significant activity in states that may have no EMS office resources to provide leadership or regulatory support.

Table 1



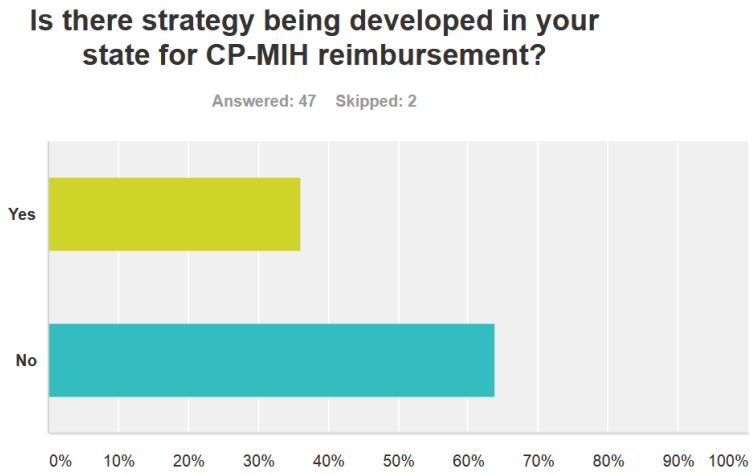
	Yes	No	Total
Support state staff involvement in CP-MIH development?	51.02% 25	48.98% 24	49
Support CP-MIH pilot projects?	36.73% 18	63.27% 31	49
Support other CP-MIH development activities?	51.02% 25	48.98% 24	49

Strategies for CP-MIH Reimbursement

Ways to fund CP-MIH services remain a puzzle. The Centers for Medicare and Medicaid Services (CMS), in an encouraging step, invited community paramedicine programs to apply for its Innovation grant series. In two rounds of funding, six CP-MIH programs received funding. Three of those programs expire in mid-2015 and sustainment is by no means assured. Minnesota has led the way in so far as employing Medicaid resources for CP-MIH support, with other states such as North Dakota pursuing legislation for similar provisions. A 2013 change in CMS rules may enable CP services to be reimbursed by Medicaid programs when a physician recommends them (see 45 CFR Parts 155 and 156) and this may be done with a change in the state's Medicaid plan. Requiring CMS approval, this process does not necessarily require statutory changes in the state. Some CP-MIH services, such as MedStar in Texas and REMSA in Nevada have had success in planning with health systems and accountable care organizations to share in savings they may help to produce.

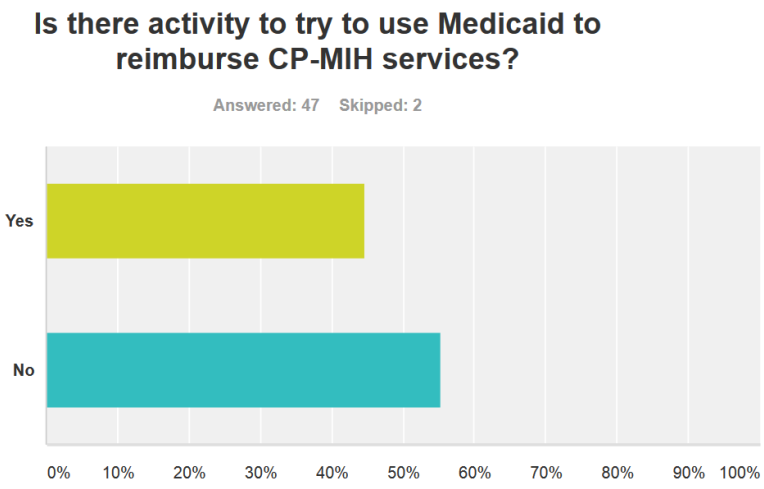
Two-thirds of the state offices responding, indicated that there is no overall strategy being developed in their states for reimbursement (Table 2). There is somewhat more activity by parties in states trying to utilize Medicaid for this purpose (Table 3) and somewhat less activity by those trying to engage third party payers to support CP-MIH (Table 4). The situation is flipped for interest by hospitals and health systems in finding ways to support CP-MIH, with activity reported in 64% of the states (Table 5).

Table 2



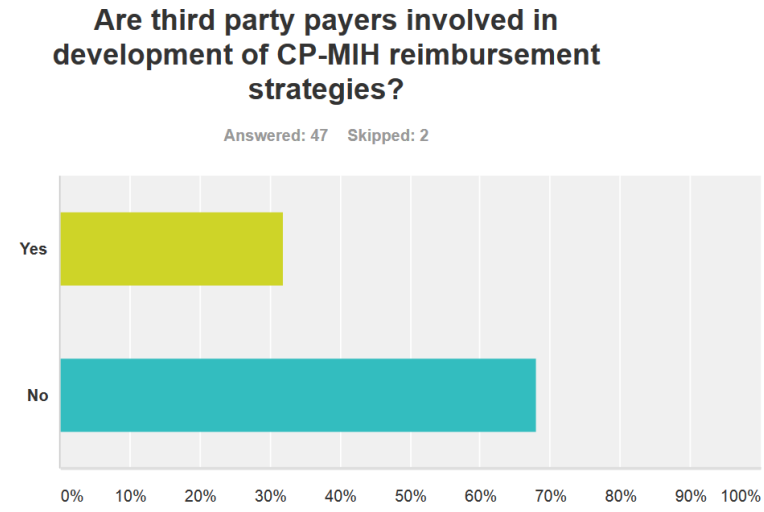
Answer Choices	Responses	
Yes	**36.17%**	17
No	**63.83%**	30
Total		47

Table 3



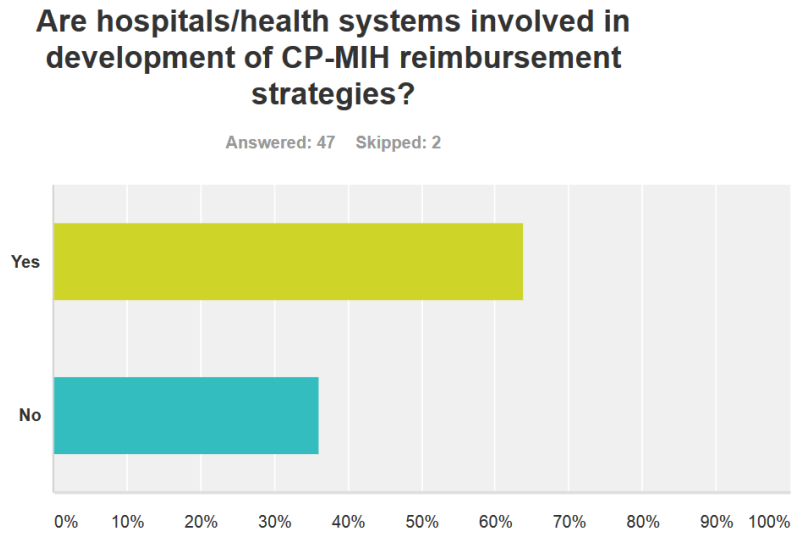
Answer Choices	Responses	
Yes	**44.68%**	21
No	**55.32%**	26
Total		47

Table 4



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

Table 5



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

Statutory Enablement/Prohibition of CP-MIH

Increasingly, state EMS offices have been called upon to interpret state statutes to interpret whether CP-MIH is a permissible activity. All 49 respondents answered questions asking whether state law has been interpreted as allowing or prohibiting CP. Twenty-five states (51%) have laws which allow CP to be practiced (Table 6) and nine states (18%) statutorily prohibit it (Table 8). The remainder have laws which do not specifically allow or prohibit it, or have not made interpretations in these regards.

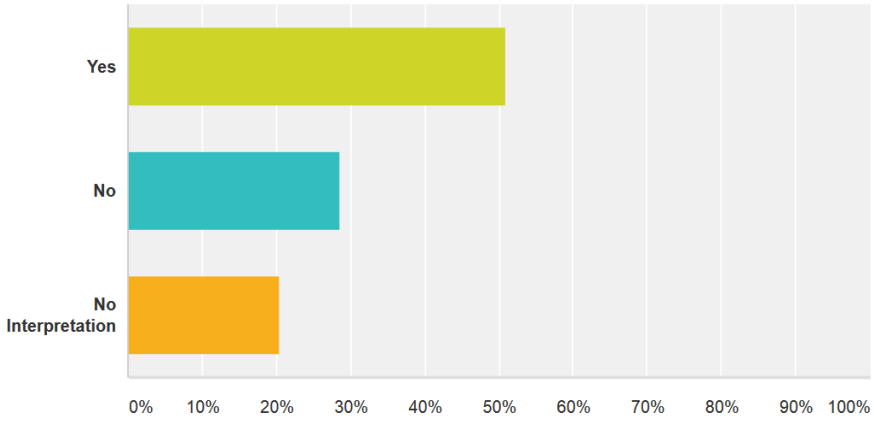
Eight states, which answered "no" to whether they have law that allows CP to be practiced, expect to have enabling legislation for this purpose within the next three years (Table 7).

Seven states have had changes in law or regulations to address CP (Table 9). It is believed that most, if not all, of these were changes to enable CP.

Table 6

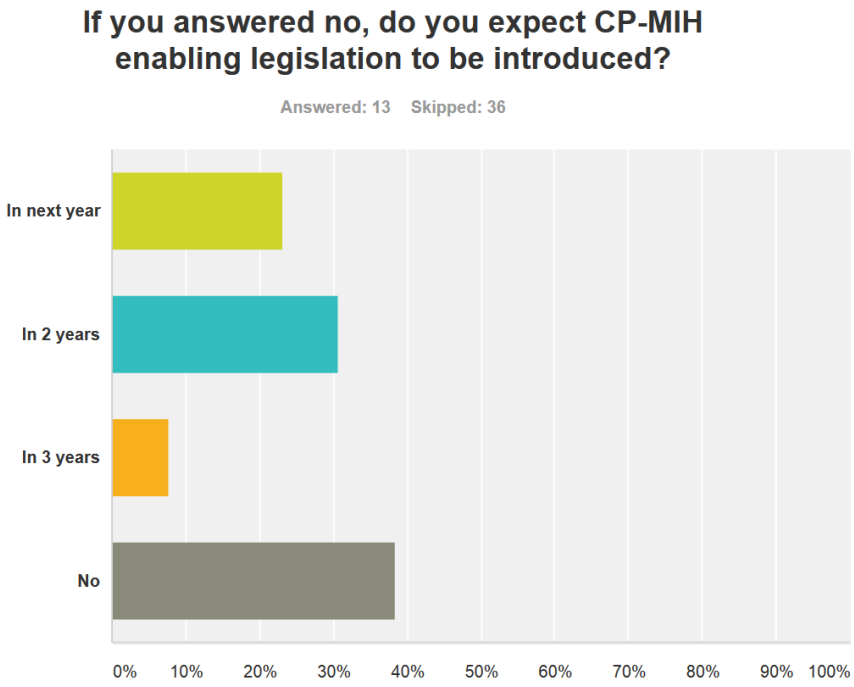
Have you interpreted your EMS enabling statute as allowing community paramedicine (within your scope of EMS practice for those individuals) to be provided in the State?

Answered: 49 Skipped: 0



Answer Choices	Responses	
Yes	**51.02%**	25
No	**28.57%**	14
No Interpretation	**20.41%**	10
Total		49

Table 7

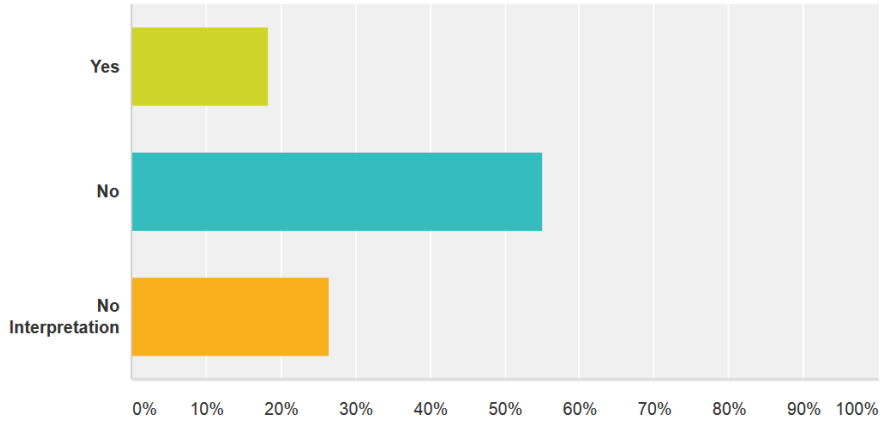


Answer Choices	Responses	
In next year	**23.08%**	3
In 2 years	**30.77%**	4
In 3 years	**7.69%**	1
No	**38.46%**	5
Total		13

Table 8

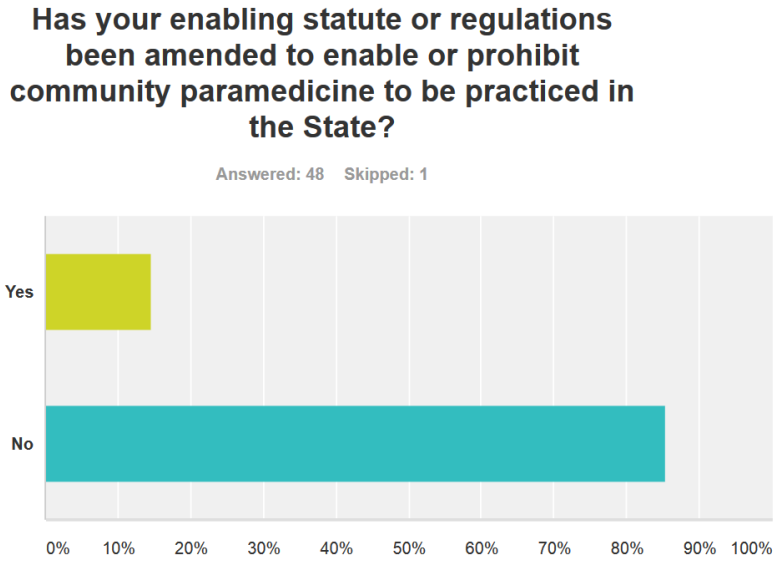
Have you interpreted your EMS enabling statute as prohibiting community paramedicine (within your scope of practice for those individuals) to be provided in the State?

Answered: 49 Skipped: 0



Answer Choices	Responses	
Yes	**18.37%**	9
No	**55.10%**	27
No Interpretation	**26.53%**	13
Total		49

Table 9



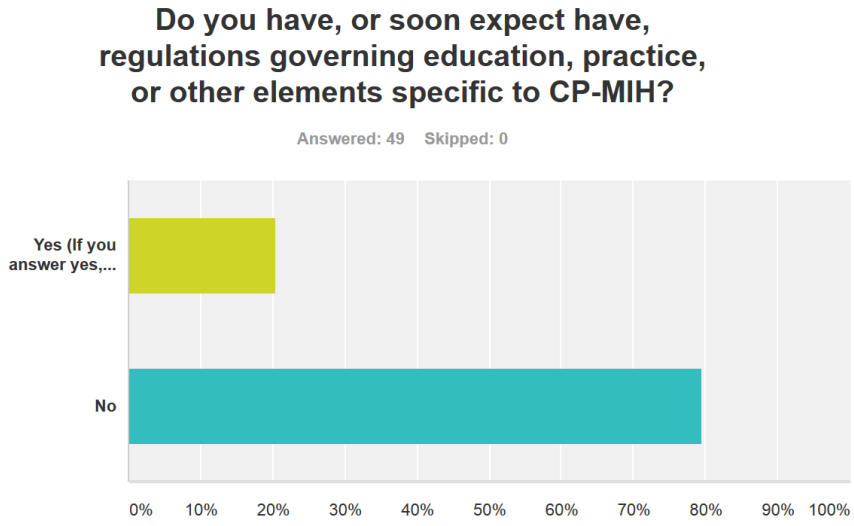
Answer Choices	Responses	
Yes	**14.58%**	7
No	**85.42%**	41
Total		48

Regulatory Aspects of CP-MIH

Ten states said that they have or would soon have regulations governing aspects of CP-MIH (Table 10). While most respondents skipped the question on plans to license/certify CP-MIH personnel or agencies (Table 11), underscoring the early regulatory and developmental stages in which CP-MIH finds itself, 18 respondents indicated that they plan to license/certify CP-MIH personnel while 10 stated that they plan to license/certify CP-MIH agencies. This is somewhat more activity in this area than leaders expected at this stage of CP-MIH evolution.

Only three states have enabled scope expansion beyond the current scope of practice while 46 have not. By example, Minnesota allows suturing (Table 12).

Table 10



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

Elaboration for Table 10 was requested by way of links to any regulations that may exist. The status of regulations in development has also been of interest to state EMS offices so is included below.

American Samoa: "AS has no enabling legislation for any EMS activity. Legislation is being drafted and CP is a component of that."

Louisiana: "In development now."

Minnesota: "https://www.revisor.mn.gov/statutes/?id=144E.28."

Missouri: "Regulations being drafted at this time."

Nebraska: “I predict within five years we will have some sort of legislation. There is a debate that there is no need for special legislation in Nebraska. Changing the wording in the scope of practice law already gives providers to practice. There has been no challenge to this yet.”

Nevada: “Still in the early bill draft requests (BDR)”

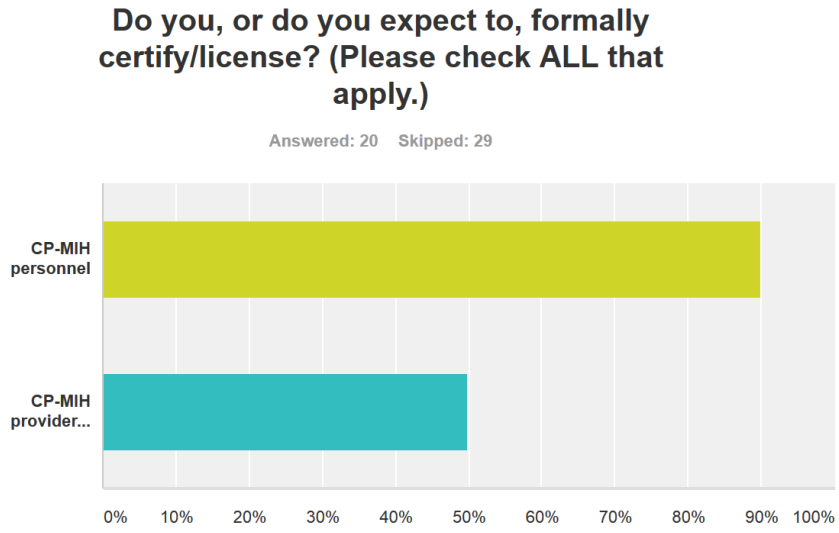
New Mexico: “http://archive.nmems.org Supplemental Provisions (Scope of Practice) 7.27.11.”

North Dakota: “Not yet published. In administrative rule review process.”

Northern Marianas: “No link at present.”

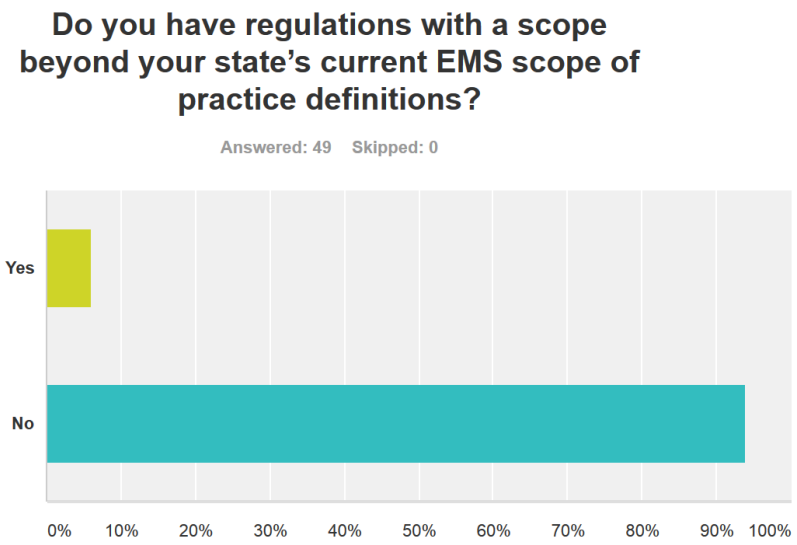
Rhode Island: “Draft status at this time.”

Table 11



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

Table 12



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

Medical Direction

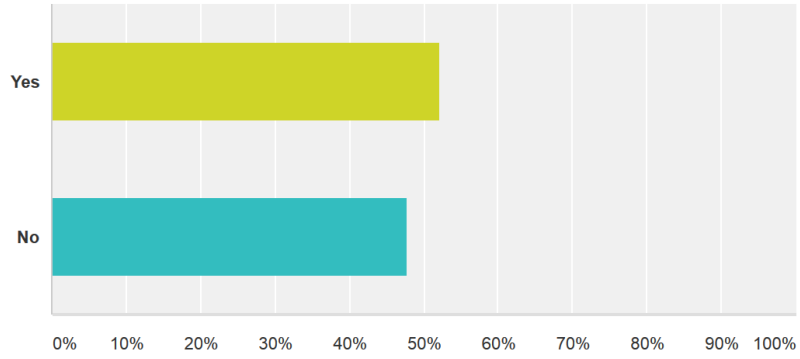
Forty-six respondents replied to a question asking whether medical direction is required for agencies providing CP-MIH specifically for that activity (Table 13). Respondents were fairly evenly split. Respondents that answered affirmatively were asked about the nature of the relationship between the CP-MIH and EMS medical directors (Table 14). Of the 24 that replied, nine each said that the CP-MIH medical director coordinates with the EMS medical director or were the same person. Three said that the CP medical director reports to the EMS medical director.

Forty-two and 40 respondents, respectively, answered questions about the availability of on-line medical direction or standing orders for CP-MIH (Tables 15 and 16). Sixty-two per cent said that on-line medical direction is available, and 48% said that standing orders are available. The former seems to reflect states in which medical direction availability is required of all services, even though special provisions may not have been made for CP. The latter, on the other hand, seems to more accurately reflect standing orders derived for CP programs.

Table 13

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

Answered: 46 Skipped: 3

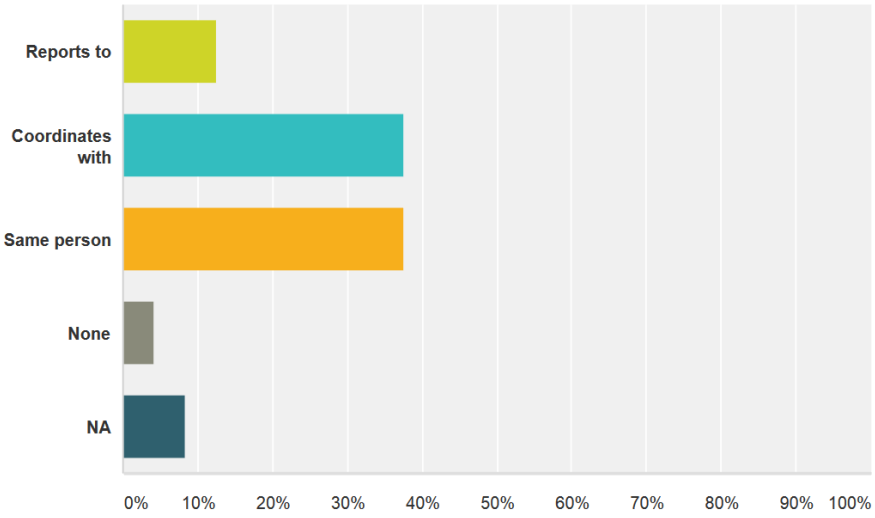


Answer Choices	Responses	
Yes	**52.17%**	24
No	**47.83%**	22
Total		46

Table 14

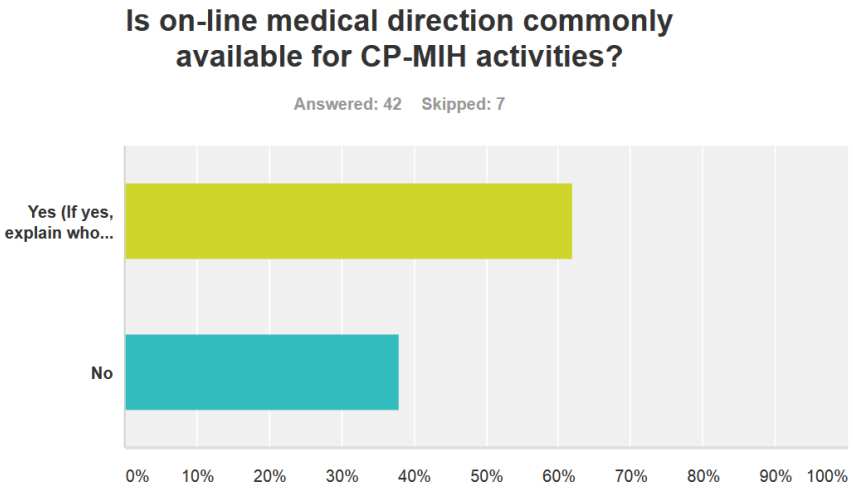
If yes, what is the relationship with the EMS medical director?

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

Table 15



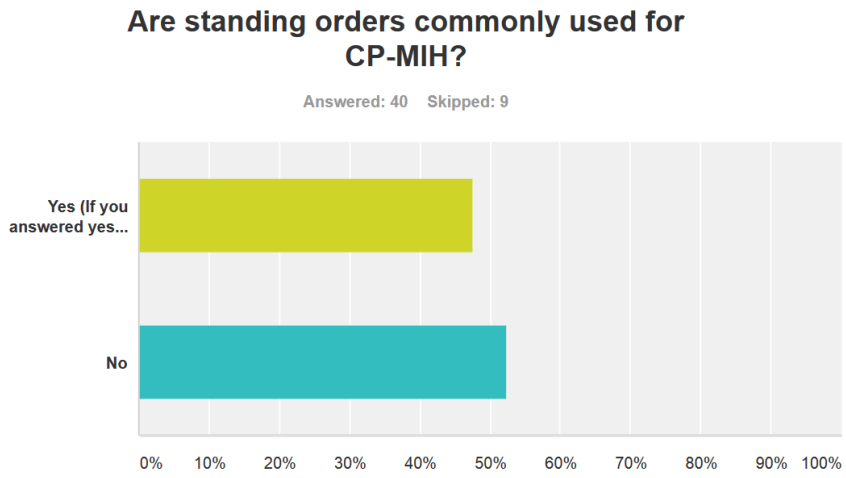
Answer Choices	Responses	
Yes (If yes, explain who provides this medical direction in the box below.)	**61.90%**	26
No	**38.10%**	16
Total		42

Table 15 asks for elaboration: "If yes, explain who provides this medical direction…" The following is a sampling of state EMS office responses.

- "Regional medical advisory committees, ED doc and service medical directors."
- "This would depend on the agency providing community paramedic services."
- "Not that far along with planning to identify anything other than online with Medical Director."
- "The CP medical control physician."
- "Can be service director or a care facility physician."
- "Medical Direction is provided through the provider's agency medical director."
- "The Service Medical Director".
- "Agency medical directors."
- "EMTs and paramedics are required to have medical direction either through protocol or offline medical direction."
- "Local Medical Directors."
- "Base Station Hospitals."
- "Sponsoring physician for clinic."
- "The agency providing the service would determine this."
- "Both telephone and EHR communications."
- "Through hospital or provider medical director."
- "Service EMS medical director."
- "Georgia licensed ambulance services are required to have a medical director and those engaged in CP-MIH are getting medical direction from their local medical director."

- “Olathe has physician assistants present with a paramedic acting as the medical direction I am unsure of the medical direction for the others.”
- “Current law only allows paramedic practice with availability of medical control.
- “Available when needed.”
- “Their normal on-line medical control .The receiving hospital is required to provide on-line for any EMS agency that calls them. Resource Hospital Minimum Requirements. A resource hospital must meet the following minimum requirements: (1) Be licensed in Utah or another state as a general acute hospital or be a Veteran's Administration hospital operating in Utah. (2) Have the ability to communicate with other EMS providers operating in the area. (3) Provide on-line medical control for all prehospital EMS providers who request assistance for patient care, 24 hours-a-day, seven days a week. A resource hospital must also: (a) create and abide by written prehospital emergency patient care protocols for use in providing on-line medical control for prehospital EMS providers; (b) train new staff on the protocols before the new staff is permitted to provide on-line medical control; and annually review with physician and nursing staff (c) annually provide in-service training on the protocols to all physicians and nurses who provide on-line medical control; and (d) make the protocols immediately available to staff for reference. (4) The on-line medical control shall be by direct voice communication with a physician or a registered nurse or physician's assistant licensed in Utah who is in voice contact with a physician.”
- “Agencies medical director or another command physician as needed.”

Table 16



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

Table 16 asks for elaboration: “If yes, explain who develops these standing orders”. This is a sampling of state EMS office responses.

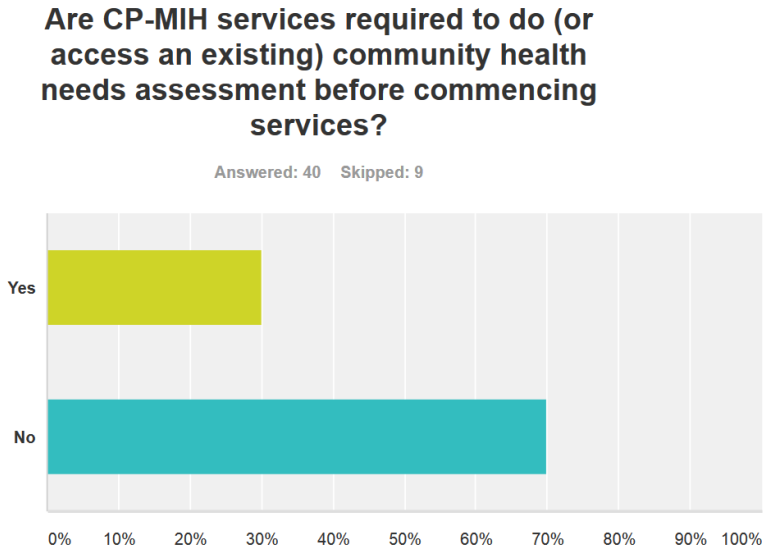
- “Pilot protocol developed by state Protocol Review Committee and approved by the oversight (EMS Board). EMS providers functioning within their scope of practice.”
- “Demonstration project doctors.”
- “This would depend on the agency providing community paramedic services.”
- “The provider's CP coordinator.”
- “EMS Agency developed.”
- “Agencies and Supervising Hospitals are currently developing these.”
- “The Service Medical Director.”
- “Agency medical director.”
- “By State and Local Protocols.”
- “Written Protocols developed and approved by the Local EMS Agency.”
- “The EMS Agency's Medical Director.”
- “Each agency is currently responsible for developing their own protocols that are approved by the medical director(s).”
- “Service EMS medical director and PCP medical director - must be approved by state EMS medical board.”
- “Georgia ambulance services use standing orders/medical protocols developed by their medical director. Those engaged in CP-MIH are using standing orders/protocols developed by their medical director.”

- Must have approved protocols.
- “At the agency level and in our case Salt Lake City Fire Department.”

Community Health Needs Assessment/Integration with Community Health Team

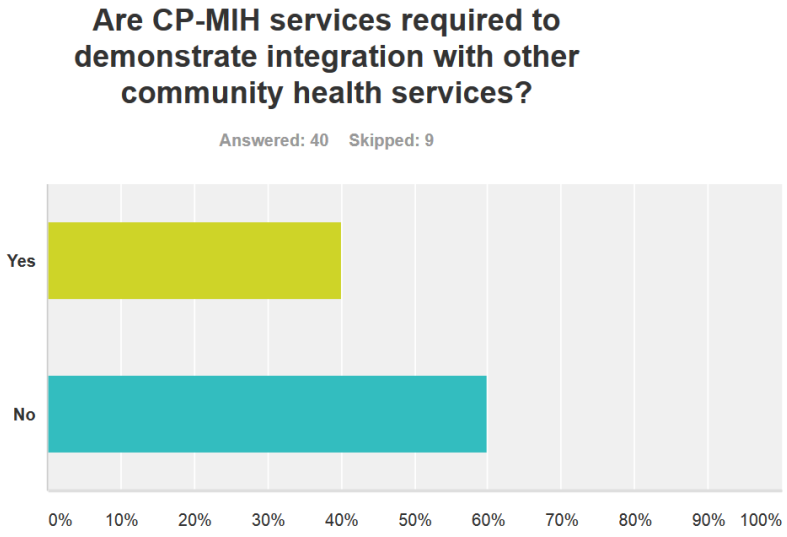
For 40 respondents, only 30% indicated that a community health needs assessment must be performed or accessed before CP-MIH services are started, and 40% require a demonstration of integration with other health services (Tables 17 and 18). For respondents who answered "yes" to the question on integration, Table 19 demonstrates wide integration.

Table 17



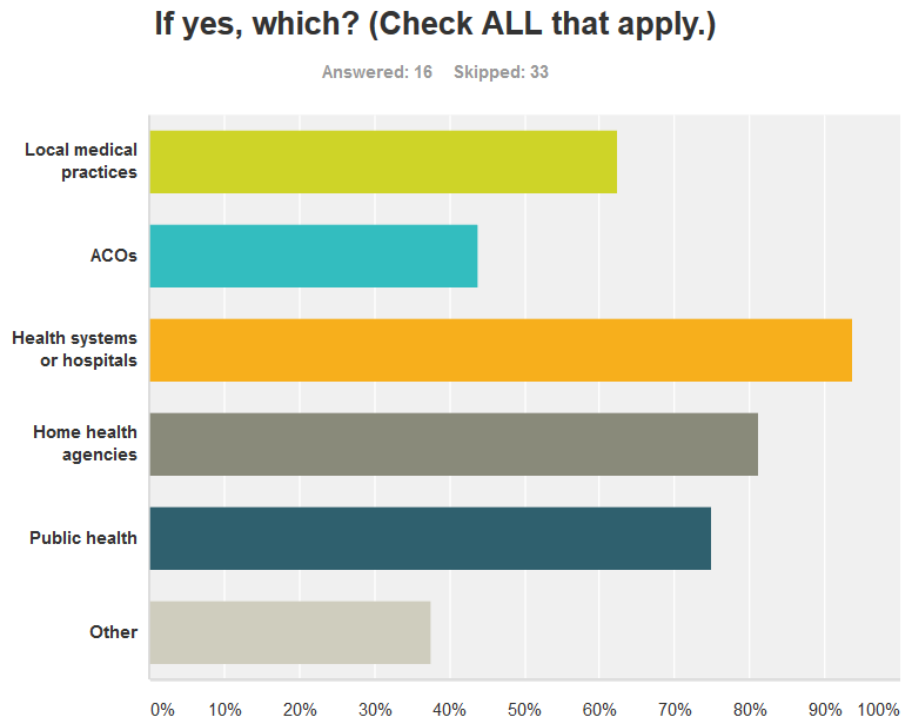
Answer Choices	Responses	
Yes	**30.00%**	12
No	**70.00%**	28
Total		40

Table 18



Answer Choices	Responses	
Yes	**40.00%**	16
No	**60.00%**	24
Total		40

Table 19

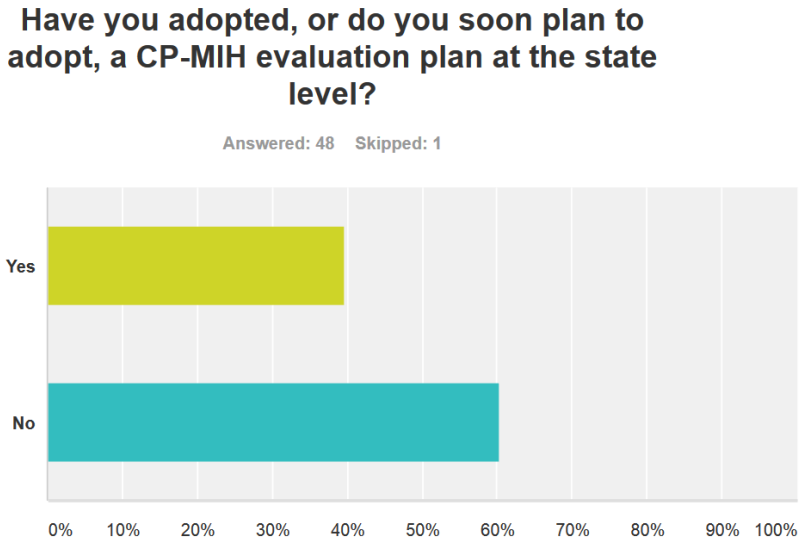


Answer Choices	Responses	
Local medical practices	**62.50%**	10
ACOs	**43.75%**	7
Health systems or hospitals	**93.75%**	15
Home health agencies	**81.25%**	13
Public health	**75.00%**	12
Other	**37.50%**	6
Total Respondents: 16		

CP-MIH Evaluation

Of 48 respondents, 60% said that they have, or plan to have, state level evaluation for CP-MIH service (Table 21), and 15% have already established state-level benchmarks (Table 22). For those states not having benchmarks for CP-MIH, 17% indicated that they require services to have such benchmarking (Table 23). Finally, 46 respondents said that 48% of their CP-MIH agencies have QI measures in place regardless of state requirements while 5% do not (Table 24 – the rest have inadequate information or situations that don't apply).

Table 21

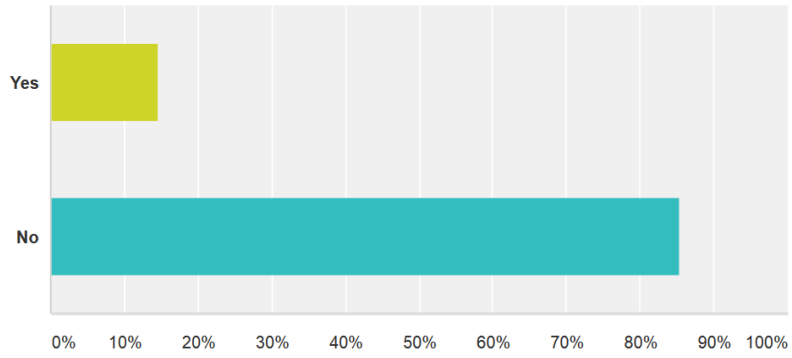


Answer Choices	Responses	
Yes	**39.58%**	19
No	**60.42%**	29
Total		48

Table 22

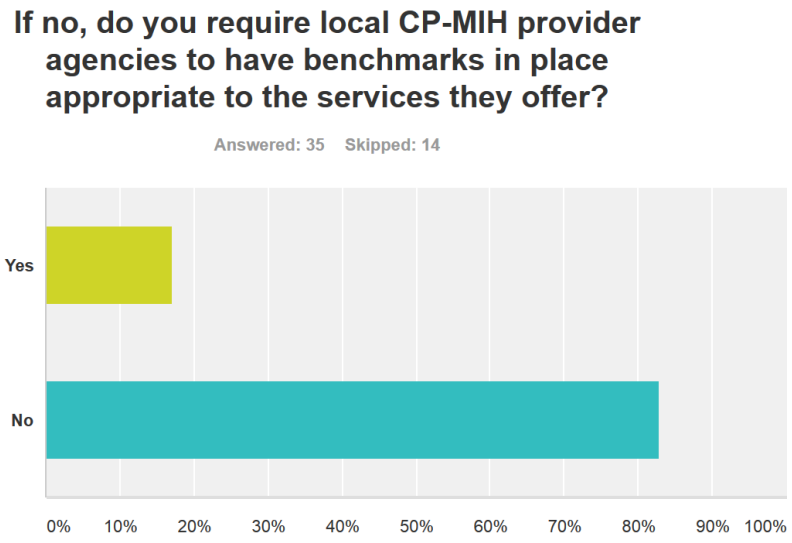
Have you established state-level benchmarks or indicators against which to measure the relative success of CP-MIH services?

Answered: 48 Skipped: 1



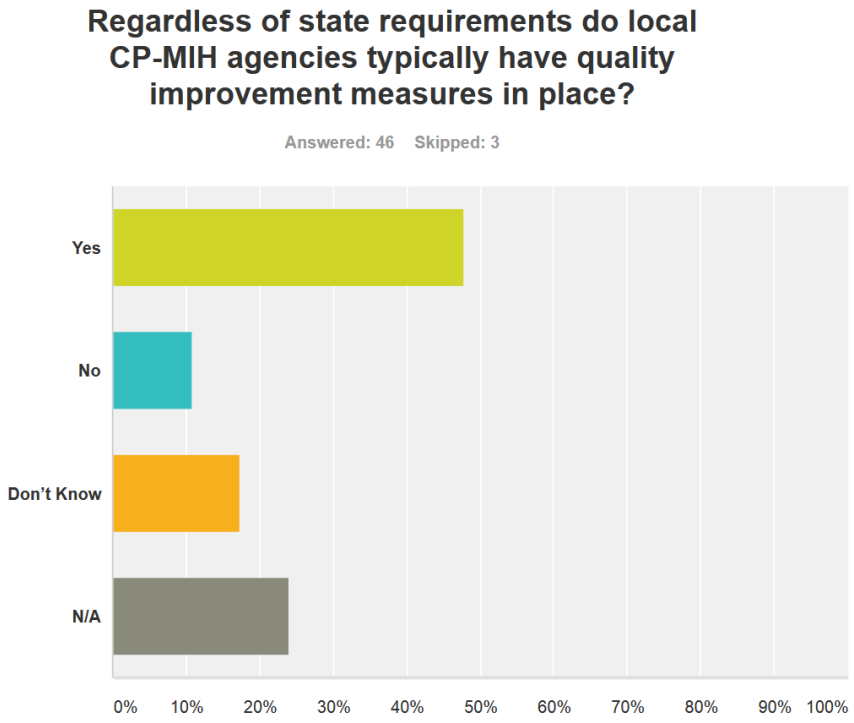
Answer Choices	Responses	
Yes	**14.58%**	7
No	**85.42%**	41
Total		48

Table 23



Answer Choices	Responses	
Yes	**17.14%**	6
No	**82.86%**	29
Total		35

Table 24

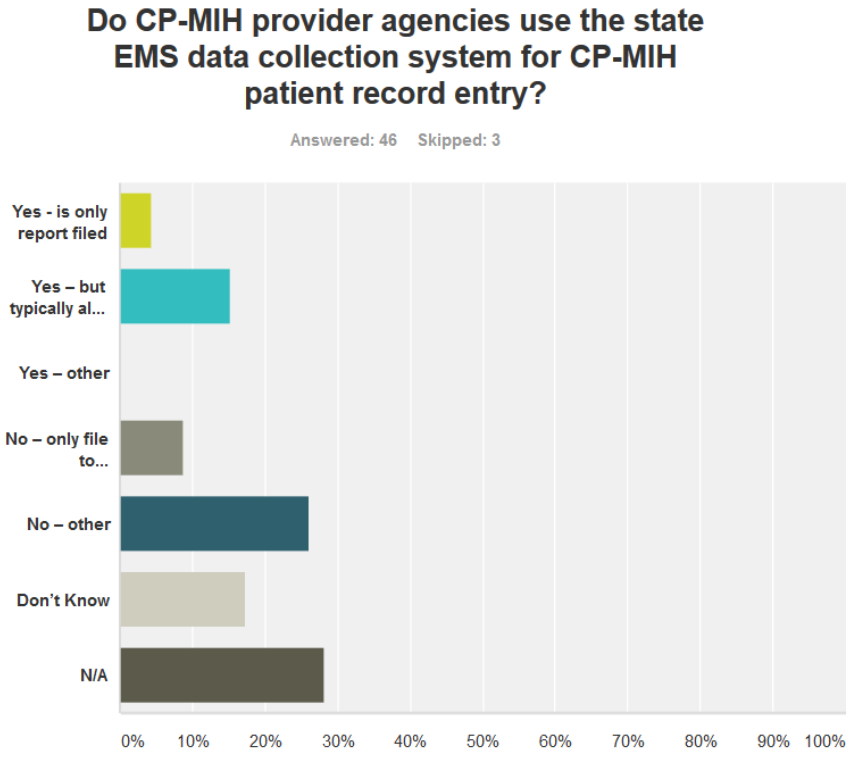


Answer Choices	Responses	
Yes	**47.83%**	22
No	**10.87%**	5
Don't Know	**17.39%**	8
N/A	**23.91%**	11
Total		46

Data Collection/Patient Record Communication

Table 25 indicates inadequate patient record and patient record communications systems for CP-MIH. Current e-PCR systems have proven unable to support the primary care services of CP-MIH. The variety of systems used by local medical practices, EMS systems, hospitals, health systems, and health information exchanges makes integration and communication of CP-MIH patient medical records difficult.

Table 25



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

List of Weblinks or Resources of CP-MIH Interest

Respondents provided state recognized weblinks to CP-MIH related resources. These are listed below. These will also be listed and updated on the NASEMSO website, along with national resource lists in the future.

- Arizona Bureau of EMS & Trauma System: Community Paramedicine
- Maryland Institute for EMS Systems: Medical Protocols *(starts on page 403)*
- Minnesota Ambulance Association: Community Paramedic
- Minnesota Statutes: 144E.28 subd. 9 & 2546B.0625 Subd. 60
- North Dakota Division of EMS & Trauma: CP Pilot Program
- South Carolina Abbeville Area Medical Center:
    - Community Paramedic Program *(10/22/2013)*
        - Abbeville launches unique program to reduce readmissions *(10/22/2013)*
    - Community Paramedic Program Grant Received *(7/7/2013)*
    - http://youtu.be/mXcbGjryOT4
- Virginia Office of EMS: MIH/CP Licensure Requirements

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