

BLUEPRINT FOR COMMUNITY PARAMEDICINE PROGRAMS ESPECIALLY FOR EMS AGENCIES



Specific to South Carolina 

Version 1: The Abbeville Experience

South Carolina Office of
Rural Health 

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South Carolina Office of Rural Health

The South Carolina Office of Rural Health is a 501(c) 3 non-profit organization that is located in Lexington, South Carolina. Since 1991, the SC Office of Rural Health has worked tirelessly to provide solutions to ensure that equitable access to quality healthcare is available for all residents in rural South Carolina. SCORH is devoted to improving the health status of rural and underserved people through:

- advocacy
- education
- assistance to providers
- assistance to communities
- assistance to policymakers



"The South Carolina Office of Rural Health is committed to serving our rural and underserved communities. Whether you work with a small rural hospital, Rural Health Clinic, free clinic, Federally Qualified Health Center, private physician's office or EMS service, we want to make sure that we assist your efforts to improve access to quality health care in rural communities."

*Graham Adams, PhD
Chief Executive Officer
SC Office of Rural Health*

SCORH strives to ensure that rural and underserved South Carolinians have optimal health care services that enhance the quality of life in every community across the state. The core programs at SC Office of Rural Health include:

- Rural Health Clinic Services
- Rural Recruitment Services
- Revolving Loan Fund
- Small Rural Hospital Programs
- EMS Innovation Programs
- Rural Health Networks
- Health Information Technology Services
- Economic Impact Studies
- Preferred Partners
- Low County Healthy Start

Additionally, the SC Office of Rural Health serves as a clearing house for all rural health information and research for the state. Overall, the staff at the South Carolina Office of Rural Health can help connect people to the most useful resources, healthcare providers and healthcare entities to find current and useful information; whether this information is related to data, resources, or regulatory compliance in the State of South Carolina.

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Trail Blazers:

The Community Paramedic Program Handbook¹ created by Western Eagle County Health Services District (WECAD) and the North Central EMS Institute has paved the way for other Community Paramedicine programs. The Program Handbook was essential to the Abbeville Community Paramedicine program. Our state specific toolkit is a companion to the Community Paramedic Program Handbook; please see WECAD's Handbook prior to reading this Blueprint.

Essential Contributors:

There are numerous contributors that were essential to the development of the Abbeville Community Paramedicine (CP) program. Initially, we would like to thank all the Community Paramedicine programs that have come before the Abbeville CP program; these programs have laid the groundwork for Abbeville and all other Community Paramedic programs to come. We would also like to thank Christopher Montera and Anne Robinson at Western Eagle County Health Services District; Matt Zavadsky and Sean Burton at MedStar; and Michael Bachman at Wake County EMS. Thank you all for providing directions, materials and best practices to Abbeville's Community Paramedicine program. Additionally we would like to thank Gary Wingrove from the North Central EMS Institute and Matt Womble from Womble Consulting. In addition, we would like to thank the National Organization of State Offices of Rural Health and the Joint Committee on Rural Emergency Care. Lastly, we would like to thank The Duke Endowment for its financial contribution to the Abbeville Community Paramedicine program. You all are essential contributors and you helped in the creation Abbeville's Community Paramedicine program. Many Thanks!

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¹ Community Paramedic Program Handbook: <http://communityparamedic.org/Program-Handbook>

The Purpose and the “How To” Section

Purpose:

The Blueprint was designed around the resources and tools that were paramount in the development of Abbeville’s Community Paramedicine (CP) program. Version one, The Abbeville Experience, showcases examples, resources, tools, recommendations, lessons learned and best practices. As a result, the Blueprint is specific to South Carolina and is geared towards EMS agencies. We hope that this Blueprint will be a useful toolkit for other healthcare providers that are interested in starting the journey of implementing a Community Paramedicine program.

While we hope this blueprint will be a useful tool in navigating the road to a unique, effective and sustainable Community Paramedicine program, it is important to state that this Blueprint is a living document that will be revised, updated, and changed. Please use this document as a point of reference for developing your Community Paramedicine program.

Additionally, even though this toolkit was developed to help others navigate Community Paramedicine program development in South Carolina, it is *not* an exact roadmap. We cannot guarantee that your Community Paramedicine program will be successful. This toolkit was designed to help you build your program; however, no two Community Paramedicine programs are alike. What worked for Abbeville, South Carolina might not work for your community and it is your responsibility to identify what will work for you and your community.

How To:

The Blueprint has three levels of information:



Level 1 illustrates the general course of action needed for developing a Community Paramedicine program in South Carolina; this is done through directions, recommendations and steps. Level 2 depicts the best practices and lessons learned from the Abbeville CP program. Lastly, Level 3 includes relevant documents and tools for current and future reference.

Version 1: The Abbeville Experience

Abbeville Community Paramedicine Program

The Abbeville Community Paramedicine (CP) program is being implemented in Abbeville County, South Carolina. By utilizing Community Paramedics² in an expanded role but within their current scope of practice, they are providing non-emergent, low-acuity care that is consistent with the Medical Home Model³. Abbeville's Community Paramedics, with a physician's order and patient's consent, are conducting home visits. The Abbeville CP program's mission is to "bridge the gap of unmet health care needs for the citizens of Abbeville providing for a healthier and safer community while reducing the unnecessary accrual of healthcare costs, providing medical care to the underserved, improving our patients' quality of life and ensuring a whole community approach to preparing for disasters." There are three main goals of Abbeville's Community Paramedicine Program; these are:

1. Strengthening the Primary Health Care Delivery System
2. Implementing Change in Patient Outcomes and Reduced Health Care Costs
 - a) Reducing Non-Emergent 911 calls
 - b) Reducing Non-Emergent ED visits
 - c) Reducing Inpatient Hospital Readmissions
3. Meeting Unmet Health Care Needs

The Abbeville program officially started on October 1, 2013 and is currently funded to run until July 30, 2015. The program partners include Abbeville County Emergency Medical Services, Abbeville Area Medical Center, The South Carolina Office of Rural Health, The South Carolina Rural Health Research Center, The Duke Endowment, and the South Carolina Department of Health and Environmental Control. The targeted population is 100 unduplicated patients annually.

Abbeville's Community Paramedics

There are three primary Community Paramedics that staff the Abbeville CP program. The Community Paramedics are Brandon Johnson, NREMT-P; Eric Livingston, NREMT-P; and David Payton, NREMT-P. Will Blackwell, NREMT-P, who serves as a backup Community Paramedic. Abbeville's Community Paramedics are truly the heart of the Abbeville Community Paramedicine program. These Community Paramedics work their traditional EMS roles on top of their new Community Paramedic roles at Abbeville County EMS. Brandon Johnson is currently a Shift Supervisor and has over thirteen years of EMS experience. He has been a Paramedic since 2008. Eric Livingston is an Assistant Supervisor, has twelve years of EMS experience and has been a Paramedic for the last seven years. David Payton is also an Assistant Supervisor and has over twenty three years of firefighter and Paramedic experience. Will Blackwell is the Deputy Director of Emergency Services. He has over twelve years of EMS and fire service experience and has been a Paramedic since 2007.

² **Community Paramedicine**, as stated by the U.S Department of Health and Human Services, is an organized system of services, based on local need, provided by emergency medical technicians and paramedics that is integrated into the local or regional health care system and overseen by emergency and primary care physicians.

³ **Medical Home Model** is defined as patient-centered care that is led by a physician who is coordinating all aspects of preventive, acute and chronic care, using the best available evidence and technology.

The Abbeville Story

In October 2011, David Porter joined Abbeville County EMS as their EMS Director. David was intrigued by the idea of Community Paramedicine and all that it had to offer for rural communities. Determined to see a Community Paramedicine program come to fruition, David started asking around about Community Paramedics. Eventually, David was advised to call Melinda Merrell at the South Carolina Office of Rural Health. Melinda, at the time was aware of Community Paramedicine and how paramedics can be utilized, in an expanded role but within their scope of practice, to bridge healthcare gaps in the community. Melinda and David had a few conversations regarding how to get a Community Paramedicine program up and running. Shortly after Melinda and David started talking about CP, the CMS Innovation Challenge Opportunity was released and there was an opportunity to become involved in a national Community Paramedicine grant as a pilot site. David and four other Abbeville paramedics got involved in the grant and enrolled in the Community Paramedicine class at Colorado Mountain College in February 2012. Although the innovation grant was not awarded to the national group, this training set up the opportunity for Abbeville to apply for a care transition grant with The Duke Endowment. The application process also allowed Abbeville Area Medical Center to take on an even bigger role in the Abbeville Community Paramedicine pilot program. The development of the CP program in Abbeville started on many levels; the partnership between the entities was essential for success.

The focus of the Abbeville CP program is around Hypertension, COPD/Asthma, Diabetes and Congestive Heart Failure. These were chosen based on the need of the community and training of the Community Paramedics. The needs of Abbeville County were identified in a couple of ways. Initially, Abbeville's need for a CP program was identified anecdotally; David Porter played a large role in this. David talked to numerous healthcare providers and stakeholders in and outside of Abbeville County. He was able to spark interest in the Community Paramedicine concept and local healthcare providers started to identify needs that the Community Paramedics could address. The second way needs were identified in Abbeville County was through the utilization of publicly available data from various sources. The sources include SC Medicaid data, US Census data, data from the local 911 system, SC DHEC chronic disease profiles, etc. Lastly, the identified needs in Abbeville were organized in a proposal format; which included demographics, health status, and utilization of healthcare services in the county. The health indicators showed that a large number of Abbeville residents are suffering from COPD and utilization demonstrated that there were numerous non-emergent ED visits and 911 calls.



- [News Articles on Abbeville's Community Paramedicine Program](#)

Introduction to Community Paramedicine Programs

Community Paramedicine

Community Paramedicine is a relatively new term that was first introduced in the early 2000's and is now getting a lot of attention both nationally and internationally. Community Paramedicine programs are being used to increase access to primary and preventive care, provide wellness interventions within the medical home model, decrease emergency department utilization, save healthcare dollars and improve patient outcomes using emergency medical service providers in an expanded role⁴. These programs are supportive of the overall changes in healthcare happening now in the US.

Initially, Community Paramedicine programs were geared towards enhancing community health. Like most new ideas, Community Paramedicine programs have evolved beyond just enhancing community health and are now being implemented nationally for numerous reasons. While Community Paramedicine programs differ substantially from each other, most programs have been geared towards post discharge care, chronic disease monitoring, patient education and primary care services outside of traditional health care settings³. Ultimately, all of these programs are hoping to reduce non-emergent ED visits, inpatient readmissions and inappropriate utilization of healthcare resources. Thus, Community Paramedicine programs are attempting to bridge the health care gaps in both urban and rural settings.

At the national level, the term "Mobile Integrated Healthcare" is being used as an overarching phrase for non-emergent, pre/post hospital EMS care initiatives. The National Association of Emergency Medical Technicians defines Mobile Integrated Healthcare as "the provision of healthcare using patient-centered, mobile resources in the out-of-hospital environment"⁵.

National Community Paramedicine Programs

In this section, the National Community Paramedicine programs have been divided into Community Paramedic and Other Expanded Role Programs.

1) Community Paramedic

Western Eagle County Health Services District (WECAD Model)

The Western Eagle County Health Services District, commonly known as WECAD, served 54,000 residents in Eagle County, CO. The goal of their Community Paramedic program is to "improve health outcomes among medically vulnerable populations and save healthcare dollars by preventing unnecessary ambulance transports, emergency department visits, and hospital readmissions"⁶. The WECAD program is predominantly known as the rural Community Paramedicine model across the nation.

⁴ Rural Health Association Policy Brief. Principles for Community Paramedicine Programs. www.ruralhealthweb.org

⁵ NAEMT. What is Mobile Integrated Healthcare. http://www.naemt.org/about_ems/MobileIntegratedHC/MobileIntegratedHC.aspx

⁶ Western Eagle county Health Services District. Community Paramedic Program Handbook. Fall 2011 Version 1.2.

Minnesota Ambulance Association: Community Paramedic

Like the WECAD Community Paramedic model, the Minnesota Community Paramedic program states that an effective Community Paramedic program supports the Triple Aim⁷: the most appropriate care for the whole population at the lowest cost. Over the past decade Minnesota has been working to fill the gaps in healthcare services in both urban and rural environments⁸. July 1, 2012 was the effective date for their Community Paramedicine reimbursement legislation⁹.

2) Other Expanded Role Programs

Mobile Integrated Healthcare Practice

MedStar in Fort Worth, Texas is currently serving more than 880,000 people¹⁰. Like WECAD and Minnesota, Medstar's goal for their EMS Mobile Healthcare program is to achieve Triple Aim. MedStar has several programs that are centered around patient navigation and Mobile Intergrated Healthcare.

Advance Practice Paramedics

In hopes of "adding a new and efficient enhancement" to their existing Wake County EMS model, the agency implemented an Advance Practice Paramedic¹¹ in January, 2009¹².

3) Other Programs

There are many others across the United States that are embarking on their own journey to Community Paramedicine program implementation. In late 2013, NAEMT released the results of a surveillance survey of Mobile Integrated Healthcare/Community Paramedicine programs. This study confirmed that many more EMS agencies than are recognized here are working to develop and implement programs. Closer to home, there are two additional programs in North Carolina that have been funded by the Duke Endowment with a similar timeline to Abbeville's program.

- New Hanover Regional EMS, Wilmington, NC
- Lumberton Rescue and EMS, Lumberton, NC

* Please see the Health Reform Glossary link below for a defined list of Affordable Care Act terms and acronyms:

http://www.hospitalmedicine.org/AM/Images/Advocacy_Image/pdf/Health_Reform_Glossary.pdf

⁷ IHI Triple Aim Initiative: Improving the patient experience of care (including quality and satisfaction); improving the health of populations; and reducing the per capita cost of health care. Accessed on March 5, 2014. <http://www.ihl.org/engage/initiatives/TripleAim/Pages/default.aspx>

⁸ McAlpin, B. *Implementing an Effective CP Program*. Minnesota Ambulance Association Community Paramedic.

⁹ Gathering of Eagles, 2013. *Why and How Minnesota is Implementing Community Paramedic Services*. The Minnesota Community Paramedic Initiative.

¹⁰ MedStar: Mobile Healthcare Programs-Overview. Accessed on November 26, 2013: <http://www.medstar911.org/community-health-program>.

¹¹ The National Rural Health Association Policy Brief defines Advanced Practice Paramedics as an expansion of scope of practice.

¹² Advanced Practice Paramedics. Wake County EMS. Accessed on November 29, 2013 at <http://www.wakegov.com/ems/about/staff/Pages/advancedpracticeparamedics.aspx>

International Community Paramedicine Programs

International Community Paramedicine programs differ slightly from Community Paramedicine programs developed in the US. The Council of Ambulance Authorities (CAA) identified three EMS models that were developed and executed in rural and very rural areas; these are the Primary Health Care Model, Substitution Model, and Community Coordination Model¹³.

Primary Health Care Model:

CAA defines the Primary Health Care Model as an "integration of health services in partnership with other health professionals, extended access to primary health services and to promote disease and injury prevention while continuing to provide pre-hospital emergency care"¹⁰. Examples of the Primary Health Care Model include:

- Ambulance Service of New South Wales (ASNSW)
- Queensland Ambulance Service (QAS)
- Community Referrals (CREMS) program in Ontario

Substitution Model:

The substitution model uses EMS personnel "in hospital emergency department as either a substitution for General Practitioners or Nurses" as described by the CAA. Examples of the Substitution Model include:

- St. John Northern Territory Ambulance Service
- Nova Scotia Community Paramedic

Community Coordination Model:

The community coordination model uses EMS personnel "in coordinator roles primarily aimed at supporting ambulance volunteers while providing the community with additional health services as required"¹⁰.

Examples of Community Coordination Model include:

- Ambulance Victoria
- St John Western Australia Ambulance Service

Lessons Learned

While Community Paramedicine programs have the potential to greatly enhance services in the communities that they are serving, the Community Paramedicine model may not be appropriate for all South Carolina communities. It is important that you STOP and consider the resources and capabilities of your community. Additionally, you will want to do whatever you can to ensure that the program is able to have a successful launch; if not, this may hurt your organization and your relationships with your

¹³ Blacker, N., Pearson, L., Walker, T., *Redesigning paramedic models of care to meet rural and remote community need*. Council of Ambulance Authorities and Ambulance Victoria: http://ruralhealth.org.au/10thNRHC/10thnrhc.ruralhealth.org.au/papers/docs/Blacker_Natalie_D4.pdf

partners impacting any future ability for a program launch. Due to the innovative nature of this type of program, an unsuccessful launch could be a big loss for your service. The checklist below will help you to think about your capacity for a Community Paramedicine program:

Community Paramedicine Checklist	Yes	No
Is there a hospital in the community that the CP program will be serving?	<input type="checkbox"/>	<input type="checkbox"/>
Is there adequate administrative time? Do you have enough staff to plan and administer a Program?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a medical control champion?	<input type="checkbox"/>	<input type="checkbox"/>
Is there a program champion?	<input type="checkbox"/>	<input type="checkbox"/>
Is your organization mature enough?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have political opponents?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have competing healthcare entities?	<input type="checkbox"/>	<input type="checkbox"/>
Is there “extra capacity” in your system?	<input type="checkbox"/>	<input type="checkbox"/>
Are you struggling to fully staff your ambulances each shift?	<input type="checkbox"/>	<input type="checkbox"/>
Will you have to shut down an ambulance to staff a CP vehicle?	<input type="checkbox"/>	<input type="checkbox"/>
Are there opportunities for funding?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have the ability to put proper checks and balances in place to keep from harming patients?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have the resources in place internally, especially in your budget?	<input type="checkbox"/>	<input type="checkbox"/>



- [Health Reform Glossary: Terms and Acronyms Defined](#)
- [National Association of Emergency Medical Technicians: 2012 Study](#)
- [Additional Information on WECAD and their Community Paramedicine Program Handbook; Minnesota’s Community Paramedicine program, reimbursement legislation, and their “Implementing an Effective CP Program” handbook; MedStar’s Mobile Intergrated Healthcare; and Wake County EMS and their Advance Practice Paramedics;](#)
- [Additional Information on the Primary Health Care Model, Substitution Model, Community Coordination Model, and related international ambulance services.](#)

Conceptualizing a Community Paramedicine Program

Every Community Paramedicine program is unique - no two are alike. The needs of communities vary from county to county, state to state, and even nationally to internationally. Here are some other definitions of Community Paramedicine:

Community Paramedicine is an organized system of services, based on local need, provided by emergency medical technicians and paramedics that is integrated into the local or regional health care system and overseen by emergency and primary care physicians¹⁴.

Community Paramedicine is a model of care whereby paramedics apply their training and skills in “non-traditional” community-based environments (outside the usual emergency response/transport model)¹⁵.

Community Paramedicine is an emerging field in health care where EMTs and Paramedics operate in expanded roles in an effort to connect underutilized resources to underserved populations¹⁶.

With these definitions in mind, it is important for the Community Paramedicine stakeholders to clearly identify and advocate for their individual community needs. Therefore, here are some important steps that are essential in identifying the foundation of your Community Paramedicine program:

Familiarize: Read all the material that you can get your hands on regarding Community Paramedic Programs, Mobile Integrated Health Care Providers, and Advanced Practice Paramedics.

Identify: Identify your community: who and what population are you trying to help?

Reach Out: Call and speak to other health care providers and EMS agencies who are involved in Community Paramedicine programs.

Develop: Start to identify key stakeholders who will be essential in the development of your Community Paramedicine program. This is a very important step and should lead to the development of an Advisory Committee for your program.

Establish Leaders: Devote time early on to identifying leaders within your Community Paramedicine program. As your program grows, the need for established champions and leaders will increase. Having a champion in each of the partner healthcare entities will ensure that the internal and external message is *consistent* and is being spread to the right *audience*. This will help your Community Paramedicine program to establish one unified message.

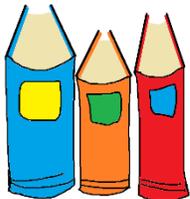
¹⁴ National Association of Emergency Medical Technicians. Community Paramedicine and Mobile Integrated Healthcare. Accessed on November 20, 2013. http://www.naemt.org/about_ems/CommunityParamedicine.aspx

¹⁵ International Roundtable on Community Paramedicine. *Definitions*. Accessed on November 2, 2013. <http://ircp.info/AboutUs.aspx>

¹⁶ HRSA-ORHP and U.S. DHHS. *Community Paramedicine Community Tool*. Accessed on December 11, 2013. www.hrsa.gov/ruralhealth/pdf/paramedicevaltool.pdf

Lessons Learned

- It is important early on to connect to state and national resources. Having a relationship with statewide and national resources will help your Community Paramedicine program meet program development needs.
- Since your Medical Control Physician will be the clinical lead of the Community Paramedicine program, it is important that the he or she is a champion for the Community Paramedicine program. Additionally, it is important that your Medical Control Physician is committed to and engaged in your program.
- The more planning that can be done up front the better; you will have lots of program development needs so you will want to try to avoid developing things purely out of necessity.
- Change is hard. Everyone knows this, but it is important to point out that you may receive a lot of resistance just due to this fact.



Resources

- [CP Advisory Committee Example](#)
- [Abbeville's Community Paramedicine Partner List](#)

Identifying Needs in the Community

Identifying needs within a targeted community can be an intimidating task; however, breaking down the properties of Community Paramedicine will help to give some direction in identifying community specific needs.



Information Collection:

This section relies on the collaboration of healthcare entities in the community; thus, it is extremely important to collaborate and continue to build relationships with key stakeholders. Keep in mind that Community Paramedicine programs are designed to fill the gaps and address the barriers to healthcare within the community. A successful Community Paramedicine program is one that does not duplicate services within the community, but one that identifies where the gaps lie and how to effectively and efficiently place Community Paramedics in these gaps. The answers to the questions below will help you to determine the environment of your healthcare community, tell your story, and make your case for your Community Paramedicine program.

Access to Care

Question	Resource	Rationale
How many hospitals are in the county that your CP program wants to serve? Is the hospital(s) a non-profit, for-profit, or governmental hospital?	<ul style="list-style-type: none"> • South Carolina Health Data http://www.schealthdata.org/ • Your local hospital, if it is a non-profit, will have a Hospital Community Benefit Report that may help your Community Paramedicine program to identify its community needs. 	<ul style="list-style-type: none"> • Understanding your community's access to care. • Identifying your community's hospital resources. • Identifying the needs of your community. Using your local hospital data/quality reports will help you get a greater understanding of your community's healthcare environment. • Assisting partnership collaboration.
What EMS agencies serve the county? Are they hospital based, county owned, rescue squads, or privately managed EMS providers?	<ul style="list-style-type: none"> • South Carolina Department of Health and Environmental Control- Division of Emergency Medical Services & Trauma (www.scdhec.gov/health/ems) • Credentialing Information System: https://apps.emspic.org/CIS/Public 	<ul style="list-style-type: none"> • Identifying your EMS providers. • Assisting partnership collaboration.
How many Primary Care Physicians are in the county? How many Primary Care offices?	<ul style="list-style-type: none"> • The South Carolina Health Professions Data Book at: http://officeforhealthcareworkforce.org/bigDocs/ohw_cdb2012.pdf • SCORH Primary Care Needs Assessment 	<ul style="list-style-type: none"> • Identifying your community's Primary care needs. • Gathering data and facts to make your CP case.

Are there any Free Health Clinics? Federally Qualified Health Centers? Rural Health Clinics?	<ul style="list-style-type: none"> SC Free Clinics Association: http://www.scfreeclinics.org/ SC Primary Health Care Association: http://www.scphca.org/ SC Office of Rural Health: www.scorh.net 	<ul style="list-style-type: none"> Identifying points of contact and potential CP program referrals. Assisting partnership collaboration
Will you be serving a Medically Underserved Area or a Health Professional Shortage Area?	<ul style="list-style-type: none"> SC Primary Care Office: https://www.scdhec.gov/health/opc/hpsa.htm 	<ul style="list-style-type: none"> Gathering data and facts to make your CP case. Identifying your community's healthcare environment.

Emergency Department Visits

Question	Resource	Rationale
What is the Emergency Department utilization? What demographic is using the ED the most in the community?	<ul style="list-style-type: none"> SC Budget and Control Board: http://hd.ors.sc.gov/default.php 	<ul style="list-style-type: none"> Understanding your healthcare environment. Helping you make your CP case. Assisting partnership collaboration
What are the health disparities in the community? Do these disparities contribute to the emergency room visits?	<ul style="list-style-type: none"> County Health Rankings: http://www.countyhealthrankings.org/ 	<ul style="list-style-type: none"> Helping you define your Community Paramedicine program. Gathering data and facts to make your CP case. Identifying potential needs of the community.

Hospital Readmissions

Question	Resource	Rationale
What discharge diagnosis is the most likely to be readmitted within 30 days to the hospital in your Community?	<ul style="list-style-type: none"> Hospital Compare: http://www.medicare.gov/hospitalcompare/search.html myschospital.org Your local hospital's quality department will have this information. 	<ul style="list-style-type: none"> Understanding your community's healthcare environment. Identifying areas where the CP program would be beneficial to CP partners. Helping to tell your story and make your case.
Is chronic disease and poor management of chronic disease a contributor to the readmission?	<ul style="list-style-type: none"> County Health Rankings: http://www.countyhealthrankings.org/ South Carolina eHealth Medicaid Statistic: http://www.schealthviz.sc.edu/ SC DHEC Data & Reports: https://www.scdhec.gov/health/epidata/index.htm 	<ul style="list-style-type: none"> Identifying community needs and potential CP area of focus Understanding your community's healthcare environment.
What quality initiative is the hospital currently implementing to help reduce readmissions?	<ul style="list-style-type: none"> Contact your local hospital and discuss their current quality initiatives. Center for Medicare and Medicaid: www.cms.gov SC Medicaid: www.scdhhs.gov 	<ul style="list-style-type: none"> Identifying current or future initiatives that the CP program could participate in. Helping you to understand the current healthcare environment in your community. Identifying potential resources.

EMS 911 Calls and Transports

Question	Resource	Rationale
What are the annual total EMS calls for the county? What percentage of the 911 calls resulted in a transport to the Emergency Department? What percentage did not?	<ul style="list-style-type: none"> County 911 Center Agency PCRs 	<ul style="list-style-type: none"> Understanding the EMS agency. Helping to make your CP case.
What was the most common acuity of patient being transported? High-acuity or Low-acuity? Emergent or Non-Emergent?	<ul style="list-style-type: none"> County 911 Center Agency PCRs 	<ul style="list-style-type: none"> Identifying transportation statistics. Understanding EMS transportation load.

Lessons Learned

- Data will help your Community Paramedicine program tell a compelling story; one to two good facts will help frame your issues.
- Since your Community Paramedicine program will rely heavily on partnerships, it is necessary to consider your relationships with your healthcare partners. Hopefully, you have a great relationship with all your essential partners; if not, this process can help you start rebuilding those connections early on in the CP program development process.
- Once you have collected data about your community, you will have to assess where there are gaps in care. One method for doing this is to “map” your community’s assets and compare them to the needs you found.



- [Need: Abbeville County, SC](#)
- [South Carolina Office of Rural Health’s Needs Assessment Outline](#)
- [Community Assets Map: Example 1](#)
- [Community Assets Map: Example 2](#)

Identifying Potential Partners

When identifying potential partners for a Community Paramedicine program, it is important to assess which healthcare agencies are impacted by your targeted improvement areas. National best practices have shown that it is extremely important that your Community Paramedicine program not compete with any other healthcare entities in the community; this is the fastest way for your program to meet resistance. In other words, it is essential that you achieve buy-in from other healthcare entities so that your program is not perceived as competition. Community Paramedicine programs should assess what local healthcare entities are financially at risk due to over or under utilization of healthcare resources. Potential partners and representatives of each include:

Partner Organization	Who Should I Connect With?
Hospital	Chief Executive Officer/Administrator
	Chief of Medical Staff
	Chief Nursing Officer/Director of Nursing
	Director of Emergency Department
	Director of Quality Improvement
	Director of Case Management
Primary Care Offices – Hospital Based	Physicians
	Practice Manager(s)
Primary Care Offices – Rural Health Clinics	Physician(s)
	Practice Manager
Primary Care Offices – Community Health Centers	Chief Executive Officer
	Chief Medical Officer
	Practice Manager(s)
	Community Health Worker(s)
Primary Care Offices – Free Medical Clinics	Board of Directors Chairperson
	Clinic Manager/Nurse
Preventive Care Offices – SC DHEC	Clinic Manager/Nurse
Emergency Medical Services – Local	EMS Director(s)
	EMS Medical Control Physician(s)
	Emergency Management Director
	Dispatch Center Director
	Training Officer(s)
Emergency Medical Services – State	SC DHEC EMS Director
	SC DHEC EMS Medical Control Physician
	SC DHEC EMS Coordinator
Long Term Care Providers – Nursing Homes	Administrator(s)
Long Term Care Providers – Home Health	Administrator(s)/Director(s)
	Outreach Nurse(s)
Long Term Care Providers – Hospice	Administrator(s)/Director(s)
	Outreach Coordinator(s)
Behavioral Health Care Providers – Community Mental Health Clinics	Clinic Director
Behavioral Health Care Providers – Alcohol & Drug Agencies (“301 Providers”)	Clinic Director
Local Coalitions – Health Coordinating Council/Coalition	Coordinator
Local Coalitions – United Way	Executive Director
Local Coalitions – Area Agency on Aging	Director
Local Coalitions – County Veteran’s Offices	Director
Educational Institutions – Regional EMS Council	Director
	Medical Control Physician
Educational Institutions – Technical Colleges	Continuing Education Director
	EMS Program Director
Educational Institutions – State Universities	Research Professor(s)

In addition to these local partners, you will want to keep in mind the state level organizations that may provide buy-in and support. In addition to the SC Office of Rural Health, you may consider the SC EMS Association and SC Hospital Association as important allies for your program. Other state level entities such as the SC Nurses Association, the SC Medical Association, and the SC Home Care & Hospice Association may be important sources of information. Finally, you should consider reaching out to healthcare payers in the state such as the SC Department of Health and Human Services for the state's Medicaid program and SC Blue Cross and Blue Shield as the state's largest commercial payer. There are also several Medicaid managed care organizations that may have an interest in your program.

Lessons Learned

- To prevent your message from getting distorted, it is imperative that you tell your Community Paramedicine story and that you tell it often.
- Meetings, meetings, meetings: To achieve an effective program, essential partners must meet on a consistent, long-term basis.
- Early on in the execution of your Community Paramedicine program, it is important that you start compiling a community resources directory.
- You and your partners will have different prioritization of activities within the program planning and implementation stages – everyone has a different definition of an “emergency”.
- There are always new people to educate about your program; you will have to be able to consistently relate to stakeholders what you are doing and why you are doing it. It will be key to translate the complexities of your program into language that everyone will understand.
- Your hospital partner(s) will likely play a very important role in your program, especially in working with your medical control physician in identifying patients for program referrals from their inpatient and emergency departments.



- [Draft Support Letter: Example 1](#)
- [Support Letter: Example 2](#)
- [Support Letter: Example 3](#)
- [Abbeville County Resources](#)
- [Community Paramedicine Resource List](#)

Outlining Your Program

Bridging Healthcare Gaps

Improving systems of care, care coordination, and strengthening the delivery of healthcare within a community is extremely beneficial to not only the healthcare entities in the area but to the residents within the community. There may be numerous gaps in your community and it is important to set community specific constraints; what is the Community Paramedicine team comfortable in doing? What are they not comfortable doing? Asking these sorts of questions will help in the collaboration and development of the Community Paramedicine program. It is important to:

1. Identify the top gaps in your community
2. Rank the identified healthcare gaps with how effectively the Community Paramedics can address these potential gaps.
3. Collaborate with your CP stakeholders and identify what area(s) have the greatest amount of interest.
4. Align the final gaps to the ultimate goal of the CP program

Once you have the basic parameters of your program outlined, it is a good idea to create a one page description of your program to be able to distribute to partners and other stakeholders.

Lessons Learned

- It can be difficult to parse out your community's needs versus their priorities. Keep in mind that there are often lots of needs but only some of those will gain traction with the resources at your disposal in your community. You may have to determine politically what needs are feasible to pursue.
- The more partners, especially physicians, you have buying into the "problem" the more support your program will get.
- The solution to your community's needs must match the resources of your community.



Resources

- [South Carolina Community Paramedicine Fact Sheet](#)

Program Sustainability

Identifying Potential Funders

Increasing concerns about healthcare reimbursements and budget cuts make for an excellent opportunity for Community Paramedicine programs to be established within South Carolina. Community Paramedicine programs strive to save healthcare dollars by utilizing already in place EMS personnel to serve their community, within their scope of practice, and thus achieving reductions in illnesses and injury and preventing unnecessary transports, ED visits, and readmissions¹⁷. Here are some ideas on how to identify potential funders:

- i. Partner Funding:
 - a. South Carolina Hospitals (Look at their current incentives and penalties)
 - b. Medicaid QI Initiatives (e.g. SC DHHS Healthy Outcomes Plans)
 - c. Accountable Care Organizations or other similar models
 - d. Local Businesses' Wellness Programs
- ii. Grant Funding:
 - a. Grants: e.g. Federal Office of Rural Health Policy grants
 - b. State & National Foundations/Endowments
 - c. The Duke Endowment (in partnership with a hospital or other eligible organization)
- iii. Other Potential Funding:
 - a. Emergency Management
 - b. Public Safety Funds
 - c. County Funds
 - d. Insurance Providers
- iv. Proposed Changes to reimbursement of EMS for Community Paramedicine

Typically to obtain financial support, a Community Paramedicine program must:

- 1) Identify your Community Paramedicine Program Case for Support
- 2) Prepare a Community Paramedicine Business Plan
- 3) Establish physician oversight for your program.
- 4) Establish and document your training program

Typical Format for Applying for a Grant:¹⁸

- Executive Summary
- Statement of Need
- Project Description
- Budget¹⁹
- Organizational Information
- Conclusion

¹⁷ NOSORH: Discussion Paper on Community Paramedicine. www.nosorh.org/resources/files/community_paramedic_programs.pdf

¹⁸ Mary, T., & Bielefeld, W. (2012). Resource Acquisition. *Managing Nonprofit Organizations*. Jossey-Bass.

¹⁹ See the Sample Budget Items in the Western Eagle County Health Services District Community Paramedic Program Handbook: Page 14.

Lessons Learned

- Everyone will ask you how you are going to get paid, especially in your local community. You will need to come up with a plan and a budget for this early in your program development.
- At this point, it is recommended that services provided by a Community Paramedic be tied to a physician to enable potential future reimbursement. For an example, see the Minnesota reimbursement model.
- Also it is recommended that Community Paramedic Training meet some minimum and/or best practice standards either from the national or state level.
- Be flexible and creative in your funding search. Does your program fit within another initiative that currently exists in one of your partner organizations? Does a potential funder have a specific angle that they are interested in? Use these types of opportunities to your advantage.



- [South Carolina DHHS: Healthy Outcomes Plan Guidelines](#)
- [South Carolina Foundation Directory, 2010](#)
- [MHCP Provider Manual- Community Paramedic Services](#)
- [PowerPoint: Giving EMS Flexibility in Transporting...](#)
- [Budget Example](#)

Program Components

Identifying Community Paramedicine Personnel

Community Paramedics are the heart and soul of CP programs; thus, the program will only be as good as its best Community Paramedic. The transition from a traditional Paramedic role to a Community Paramedic role is not a transition to be taken lightly. Here are some common skill sets and traits that will help you identify strong Community Paramedics:

- 1) Interest in Community Paramedicine
 - i. Another benefit of Community Paramedicine is that it creates an additional career path for EMS personnel.
- 2) Strong Leader
 - ii. This is especially important for your first round of Community Paramedics because these paramedics will be support for training your next round of Community Paramedics.
- 3) People Person
 - iii. A Paramedic that is able to feel comfortable and make others feel comfortable will be a great asset. Developing a good rapport with your CP patients will help to achieve patient buy-in.
- 4) Seasoned Paramedic:
 - iv. Paramedic that have extensive experience, 5 or more years, will more easily transition back and forth from a paramedic to a Community Paramedic. Experience locally is also key to building and maintaining relationships with other healthcare entities.

Lessons Learned

- Expect your service members to be open to new ideas but do not overestimate their ability to quickly adapt to the cultural change required for this type of program.
- Set minimum standards for a Community Paramedic in your service to include number of years with your service and/or number of years licensed. Consider asking potential applicants to provide a letter of intent or otherwise express their rationale in writing for wanting to become a Community Paramedic.
- Begin vetting candidates as early as possible due to the length of time training requires.
- Consider skills your CPs will need beyond patient care: how do they work with other healthcare providers and community organizations now? Do they need additional training in leadership or management skills to help them become more confident in this area?

- Expect an increase in your ability to recruit new hires as well as your ability to keep more seasoned staff on board. This could be a new career ladder for EMS in your agency and may help you retain institutional knowledge for your service.



- [Community Paramedic Job Description](#)
- [South Carolina Paramedic Skills](#)

Community Paramedic Training

Community Paramedicine education should prepare Paramedics with the skills to be able to identify community health needs and help them to address the gaps revealed by a community assessment²⁰.

It should also help Paramedics become more familiar with, and able to accept, their new role as part of the primary care team. The training needed to accomplish these goals is fundamental to any CP program development. There are many aspects to consider in creating a formalized education program for your CPs.

The first such aspect is the didactic training that the CPs will receive. Several in-house training programs exist for those services with the resources and time to develop these. There is also a national curriculum that has been developed which is currently in its third revision. The standardized curriculum created by Community Healthcare and Emergency Cooperative (CHEC) of the North Central EMS Institute has two phases. CHEC defines these phases as:

- 1) Foundational Skills
 - Comprehensive didactic instruction: advocacy; outreach and public health; performing community assessments; developing strategies for care and prevention
 - 100 hours: based on experience.
- 2) Clinical Skills
 - Supervised training: medical director; nurse practitioner; physician assistant and/or public health provider
 - 15-146 hours: based on experience.

²⁰ NOSORH: Discussion Paper on Community Paramedicine. www.nosorh.org/resources/files/community_paramedic_programs.pdf

Within these two phases, there are seven modules. As defined by CHEC; these are:

Didactic:

1. Community Paramedic's Role within Healthcare System
2. Social Determinants of Health
3. CP Role within Public Health and Primary Care
4. Culturally Competent Care
5. Community Paramedic's role within the Community
6. Community Paramedic's role in Personal Safety and Wellness

Clinical:

7. Customized to individual communities: allows for the CPs to address the care gaps in their particular community

The CHEC curriculum is currently being taught nationally in one venue, through Hennepin Technical College in Minnesota. The College is able to provide distance learning opportunities for students from other parts of the nation to attend. The next class is scheduled to start in Fall 2014; a limited number of seats will be available. Currently, there are no colleges or Paramedic programs within South Carolina that offer the CHEC curriculum; however, the SCORH is working with stakeholders to determine the feasibility of bringing the CHEC curriculum to an educational institution in the state.

In addition to the didactic training, the CHEC curriculum and in-house trainings also include clinical time. It is especially important that all clinical rotations be completed within the local community if possible and under the direct supervision of the Community Paramedicine program medical control physician. Your Community Paramedics may also benefit from field training time with a service already using CPs. MedStar is now offering this as a service to other EMS agencies:

<http://www.medstar911.org/site-visit-requests>.

A program for on-going in-service training should be developed and strictly followed as well. No national examples of CP IST currently exist.

Regardless of how you choose to structure your training program, know that it must be done and done well, and it must meet some minimum standards on par with existing CP programs. Further guidance from EMS educators in the state on how these minimum standards should be defined going forward will be critical to supporting these training programs in the future.

Lessons Learned

- Above all, the training(s) chosen should fit the needs of the community and the problems identified in the program development stage.

- Taking the time to execute meaningful rotations with community providers not only gives the Community Paramedics the training they need, but it also helps them develop the relationships that will be necessary to help make the program a success.
- Developing a regular meeting schedule with the Community Paramedics as a group through their training and development phase will support the development of program operations in the future and provide the basis for the in-service training program needed.
- Medication management may need more time and emphasis because of the learning curve with the prescriptions that patients will be taking to manage their chronic health conditions.
- Funding is a major barrier to accessing training for many agencies and is therefore one of the major roadblocks to getting started.



- [CP Clinical Tracking Chronic Disease](#)
- [Abbeville Community Paramedicine Clinical Sites](#)
- [Wake County's Advanced Practice Paramedic Academy Topics and Hours Overview](#)

Identifying Community Paramedicine Medical Control

EMS agencies run under the oversight of a physician by virtue of the delegation of practice by physicians to non-physician providers to provide care in non-clinical settings such as hospitals or physician offices. The agency's medical control physician must therefore direct the education, protocols, medical consultations, and quality assurance for the service. These same components must also be directed by a physician in a Community Paramedic program. For some services, this role may be played by the current medical control physician. In other agencies, choosing a physician with some experience in primary care may be useful in establishing the program. Agencies may also consider using different physicians for the different roles within the EMS agency, particularly if they are the primary 911 agency in their county. The medical control physicians may play separate primary and secondary roles to one another within the agency, with the primary medical control physician responsible for the traditional (911) services of the agency.

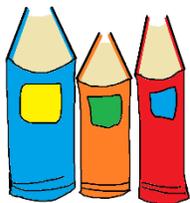
In choosing a medical control physician for your Community Paramedicine program, you will need to consider if this person is someone you work well with and if he or she would be a good champion for your program. Identifying who will be the right physician for your Community Paramedicine program

will be vital to its health as well as adoption and sustainability of your program. Additionally, since early program operations may need to have someone as a “gatekeeper” for patient visits, you will want someone who is able to devote the time to this process. He or she will need to work with the Community Paramedics to refine the program referral process, develop and implement appropriate standard operating procedures, review documentation, and then provide feedback to the Community Paramedics on care provided. This is in addition to potentially being the patient’s primary care physician for the patient being seen by the Community Paramedic.

The Community Paramedicine program medical control physician will also be key for promoting the program to other physicians in the community, which will be critical once the program begins to expand.

Lessons Learned

- Medical control physician turnover should be avoided if at all possible. Choose wisely and carefully when starting your program.
- Take the opportunity to encourage your Community Paramedic medical control physician to connect with the state Medical Control Committee and state and regional medical control physicians.
- In a small community, it works well to choose a medical control physician who is a local primary care physician that knows the types of patients who are ideal candidates for your program.



Resources

- [Medical Control Scope of Duties Example](#)

Regulatory Considerations

As the licensing and regulatory body for EMS in the state, the SC DHEC Division of EMS and Trauma is a primary stakeholder in Community Paramedicine program development. Any agencies seriously interested in pursuing a formal Community Paramedic program will need to communicate with the Division in writing. More specifically, agencies will be asked to submit a pilot proposal to the Department outlining their program's components.

At this time, the Division has not made any recommendations about the formal definition of a Community Paramedic or potential training standards in the state. National stakeholder groups such as the National Registry and the National Association of State EMS Officials may influence these decisions in the future.

It is critical that any service pursuing Community Paramedicine program development take the time to review SC DHEC Regulation 61-7 and the scope of practice for a South Carolina Paramedic in the context of their specific program plan. These are currently the maximum limits for program scope.

A service director may also want to become familiar with the regulations concerning other healthcare professional's scope of licensure standards in South Carolina. It is critical that any Community Paramedicine program be able to identify its distinction from nursing care and in particular, home health care services.

Lastly, an agency in the process of developing a Community Paramedicine program may want to review their liability insurance policies to ensure any services rendered will be covered. In most cases, since everything is within a Paramedic's scope of practice, there is no issue. However, it is recommended that this is done early in the process to avoid any issues later in the program's development and implementation.

Lessons Learned

- The Committee structures that advise DHEC on matters of EMS are longstanding and are not wholly impacted by staffing changes within the Department. In particular, the Medical Control Committee is key to this process since it is in charge of approving EMS pilot programs.
- Keeping your pilot proposal simple – and within the current scope of practice – is key.
- Relationships with nurses and other providers happen locally. While it is important to be aware of the implications of any state politics on your program, it is more important that your local

partners understand where your boundaries are. Communicating this clearly and consistently will help avoid issues of turf.

- When communicating with your partners locally, it is critical to not only disseminate program information to agency and department heads but also to follow up with their staff to ensure the message has been received on the “front lines”. This will help avoid a lot of confusion and unnecessary stress.



- [South Carolina DHEC- 1998 EMS Medical Control Manual: Pilot Project](#)
- [South Carolina Chart of Healthcare Professions](#)

Role of 911 Dispatch Center

Every EMS service in the state has a unique relationship with the dispatch center in their county. In identifying needs and local resources in pursuit of a Community Paramedicine program, every single agency should have identified their dispatch center as one of those resources. In fact, as the venue for 911 response in your county, it is critical that the dispatchers are educated about the purpose of the Community Paramedicine program and what services the Community Paramedics are providing in the community. Not only do the dispatchers need to know how to interact with any of the program patients that might call 911, they also need to know why this resource is out in the community and how it might be used in case there is a emergent staffing need in which the Community Paramedics could assist. Also keep in mind that your Community Paramedicine program may be an opportunity for dialogue in your community around 911 dispatch protocols.

By committing to regular and ongoing dialogue with the staff of the Dispatch Center, they can also play a big role in helping to identify and track patients in your health care system. Dispatchers can be crucial allies in helping identify patients when they call in; by working together, a policy can be identified and put into place that helps both the dispatcher and the Community Paramedic become more comfortable with the services being provided. In addition, by tracking the calls made by the Community Paramedic vehicle they are a key component of the data collection system.

For private services, there is still a need for interaction with the 911 dispatch center even though most of these issues are non-existent by virtue of an internal dispatch system.

Lessons Learned

- This is truly one area where different opportunities exist in each county. Take the time to explore these opportunities – you might be surprised what you learn!
- Creating special event codes in the E911 system will allow for tracking Community Paramedic home visits and 911 responses.
- The Dispatch Center’s non-emergency line can serve as backup number to the Community Paramedicine program.

Standard Operating Procedures Development

Key to Community Paramedicine program development is the creation of Standard Operating Procedures (SOPs) that fit the program’s scope. Although it is best to complete these ahead of the first program visit, they should always be considered fluid documents that will need to be constantly reviewed and changed based on program learning and further development.

Each Community Paramedicine program should at minimum have a SOP for general physical assessments, home safety assessments, and medication review. These SOPs may come from other services, but time should be taken for the program operations team to sit together and walk through the procedures to ensure they meet local standards. Once this has been done, the medical control physician should have an opportunity to review these and submit feedback. Once all parties are satisfied with the result, the agency director, medical control physician, and training officer should sign off on these and make a plan to review them at regular intervals.

One technique for illustrating a Community Paramedicine program’s SOPs is to utilize flow charts or process maps to outline the major steps in the procedure.

Additionally, there should be a SOP for what a Community Paramedic would do if an emergency is encountered while visiting a patient. Likely in every case the Community Paramedic would call 911 for an ambulance and the regular agency SOPs for emergent care by paramedics would fall into place – effectively ending the Community Paramedic visit. This is key in case the patient decides later in the series of events not to be transported to the hospital.

Other patient considerations that need to be made part of the Community Paramedicine program SOPs are obtaining patient consent and ensuring that compliance with the Health Insurance Portability and Accountability Act (HIPAA) is met. Patient consent will not only be for treatment by the Community Paramedics but for the release of medical information as necessary to coordinate care between

providers. Additionally, since your Patient Care Report system is being used to collect Community Paramedic patient outcomes, you may want to review who has access to that system periodically. If you have specific concerns, you may want to consult a healthcare attorney who specializes in HIPAA concerns.

For all SOPs for the Community Paramedic program, a Quality Assurance program should be put into place to review outcomes for consistency. The QA program may mirror what is used by the service for their emergent calls, but a more in-depth review may be necessary for the Community Paramedicine program, especially at program roll-out. To be sure, some agencies do 100% QA audits on all of their Community Paramedic patient care reports. You will need to define who comprises this audit team for the Community Paramedicine program as well as the frequency and timing of such audits with documentation of the outcome(s).

Lessons Learned

- Utilize Community Paramedic's time during training to allow them to draft and review SOPs.
- Creating additional condition specific SOPs (e.g. for COPD) allows for a very specific set of guidelines to be written; however, these must be able to be combined readily with other SOPs for patients that have multiple chronic conditions.
- Use of the terminology SOP rather than Standard Operating Guidelines puts more leverage behind the documents created; conversely, the use of the word protocol is avoided because these are not yet best practices.



- [USDHHS: HIPPA Letter](#)
- [Abbeville Community Paramedicine Program Draft CHF Protocols](#)

Program Branding

When beginning program operations, it is very important to make a distinction between your typical EMS service and your Community Paramedicine program, especially if you are the primary 911 service for the population you serve. You may choose to adopt a specific name that represents your program; you may also want to design a logo and/or select distinct colors for program marketing materials. The ways in which you market your program will include not only typical items like informational fliers and news releases, but should also include operational items for the program as well. For example, it is key that the vehicle used for a Community Paramedicine program is not an ambulance, but another type of vehicle, such as a QRV. The vehicle will need to have a similar markup as your service does, with your Community Paramedicine program name or logo added. Likewise, you will want to consider having special uniforms for the Community Paramedics to wear – a different colored shirt is attention-grabbing and separates the Community Paramedics from the other providers on shift running 911 calls. You may also want to consider how your communications setup is a part of this – creating a separate program phone number and email address will help stakeholders and potential patients identify and contact the program more easily.

Program fliers and materials should also be created to be handed out to potential patients as well as potential referral sources. Getting local media attention, especially in a rural community, is a good way to get the word out about the program. In addition, speaking at meetings or social gatherings will help your program brand spread by word of mouth. It is key to keep your messages simple, straightforward, and consistent while you are rolling out your program.

Lessons Learned

- Branding is also an important part of distinguishing Community Paramedics within the internal operations of the service. The visual impact of the different uniform and truck, both for the Community Paramedics as well as the other providers on shift, reminds every one of the Community Paramedics' new role in the service. It is key that the Community Paramedics get into and out of "character" in this role as appropriate.
- Using pictures, especially of the Community Paramedics themselves, is an important component of the branding in the community. Since Community Paramedicine programs are really all about making connections to and relationships with the community, the Community Paramedics are truly the face of the program.



- [Abbeville Community Paramedicine Flier](#)
- [Abbeville CP Truck Markup Picture](#)
- [*See the Abbeville News Articles in Appendix A](#)

Visits

Before scheduling your first patient visits, you will need to determine what shifts your Community Paramedics will work. Will you keep them on a regular paramedic shift schedule (e.g. 24/48) with certain hours/days dedicated to Community Paramedic duties? Will the Community Paramedics still have regular paramedic duties once they are “off” their Community Paramedic duty? Will you cross train other administrative or part-time support to cover Community Paramedic shifts? Or will you assign Community Paramedics to work set schedules during the day every week – only in their Community Paramedic role? In making this decisions, you will want to consider your budget as well as logistics. How does this program impact the leadership structure and capacity of your agency?

Once you have decided on a schedule for Community Paramedic coverage, you will then begin to schedule patient visits according to orders received from your referring physician(s). You may want to consider doing this in phases to ensure program integrity. The Abbeville Community Paramedicine program currently is being rolled out in a three part process: crawl, walk and run phases. The three part process is being executed to ensure compliance with applicable regulations, maintain and manage program growth and expectations, reduce the chances of negative outcomes and allow for an entrepreneurial type learning environment.

Crawl Phase

The *Crawl Phase* consists of a manageable patient load of only those that are referred by the Community Paramedicine program’s Medical Control Physician. During this phase, the Community Paramedics are available Monday through Friday between the hours of 7am to 4pm. This allows the space needed for the patient base to build incrementally as well as for the staff members of partner agencies to work out their internal processes for interfacing with the program. In addition, this phase allows for opportunities for improvements in Community Paramedicine program forms, SOPs, and program expectations; these are updated accordingly.

Walk Phase

The *Walk Phase* is focused around provider outreach. The Community Paramedicine team will start to engage interested primary care providers and Emergency Department Physicians to the Community Paramedicine program to generate patient referrals. Additionally in the walk phase, the Community

Paramedicine team will begin to work with the local Community Health Center(s), Free Clinic(s), Rural Health Clinics, as well as any partnering hospitals' Community Transitions team. In addition, the Community Paramedics will become heavily involved in the patient discharge processes from hospital to home.

Run Phase

The *Run Phase* will be geared around the Community Paramedics self-initiating calls, achieving scene referrals from other EMS crews, and 24/7 Community Paramedicine Operations. In addition, the run phase will focus on multiple provider referrals and program sustainability.

Regardless of the overall phase the Community Paramedicine program itself is in, visits with patients are standardized. On the first patient visit, the goal is to get a general idea of the patient's physical needs. Does the patient have adequate shelter and food? Does the patient have transportation issues? Are there concerns about the living conditions of the patient? Did the patient allow the Community Paramedic to complete a Home Safety Assessment? Does the patient have family or social support systems? This visit also allows the Community Paramedic to build trust with the patient and set up future visits for success. If the patient does not have a primary care physician, this visit should also be used to connect the patient with an available primary care resource in the community, even if that means the community's Free Medical Clinic. This will allow for continuity of care for the patient for at least the duration of their involvement in the program.

Once the visit is complete, the Community Paramedic completes a Patient Care Report that is submitted to the medical control physician and/or the patient's primary care physician for review. The physician(s) reviews the report for action items and next steps and determines whether an additional visit or series of visits is warranted by the Community Paramedic. If they are, the medical control physician would order these and the Community Paramedics would schedule additional visits.

If the patient is scheduled for a follow up visit, this will often give the physician an opportunity to ask the Community Paramedic to perform any number of clinically oriented tasks. This may include a general assessment, medication review and reconciliation, or other items. The information gathered from this visit will allow the physician(s) to know which course of action to take with the patient. Once the visit has concluded and the report has been submitted and reviewed by the medical control physician and/or primary care physician, he or she may order a series of visits which may be tied to a disease-specific Standard Operating Procedure, for example. Visits will continue with the patient for whatever length of time is deemed necessary by the medical control physician and/or PCP.²¹

²¹ The length of time that is appropriate for CP services is under review; however, the intent of the programs should not be to have an ongoing patient load. Ideally, patients will be able to connect with resources that will allow them to "graduate" from the CP program after a period of time.

Lessons Learned

- Scheduling Community Paramedics for duty will likely need to evolve over the course of the phased program roll-out, simply because you will not have as many patients at first. Also, though it may be more advantageous for the program if the Community Paramedics worked dedicated Monday through Friday shifts, the impact to staffing on the 911 side of the house may not be able to be overcome by many.
- It is too simple to say that Community Paramedic's services are something that they can do in their "down time". The time it takes to support the management of a patient with one or more chronic diseases is often underestimated.
- Before seeing the first patient, engaging local stakeholders in a "Table Top Exercise" of a test patient is a good way to see the flaws in your system and to discuss issues before they arise. Consider keeping this as an active part of your stakeholder engagement.
- It is often better for the patient and easier on the Community Paramedic for each Community Paramedic to have their own patient case load. This enhances continuity of care as well.
- "First, do no harm" is an important part of the program's success.



Resources

- [Abbeville CP Initial and Follow Up Visits Flow Charts](#)
- [Initial CP Visit Checklist -Draft](#)

Patient Engagement and Patient Satisfaction

Finally your Community Paramedicine program is operational – great work! Now that everything is running like you want, it is time to ramp up and get some more patients into the program. Hopefully you have done such a good job engaging your partners and keeping them energized that they have identified individuals that they know need your help and they are ready to send them your way. The issue now is – are those identified patients ready for your help?

Depending on your community needs and the criteria you identified in your initial program development, you may not be able to recruit as many willing patients into your program as you had hoped. This may mean that you need to expand your program criteria somewhat; it may also mean that there are more basic physical needs that need to be considered for patients before they are able to take

on getting the medical help that they need. This will require you to continue to work closely with your community partners to see what solutions are available. This also should give the Community Paramedics an opportunity to become more directly involved in the maintenance of these community partnerships if they are not already.

For the patients that are in your program, they are likely to be very motivated and willing to do what is necessary to maintain their health. They will still need lots of encouragement and support from the Community Paramedics to remain engaged for the long term. Your program may consider using screening tools such as the EUROQOL, PAM, or GAIN; these patient assessments can provide direction on how to best support each patient's need. The Community Paramedics should also work with their patients to set health goals – and help them figure out the baby steps they need to take to reach these goals.

Finally, you will want to measure patient satisfaction for your program. Not only is it a good way for you to understand how the “customer” values your services, but it also helps you understand the areas where you can provide better care. In measuring satisfaction, think about measuring not only individual patient responses to a few simple “how’d we do?” questions but also think more globally in terms of your program integrity. For example, did you have a lot of canceled or missed appointments with patients? What were the reasons for those and what corrective actions were used? Were these an indicator of patient dissatisfaction in any way? Working to improve operational issues such as these can gradually have a positive impact on your ability to recruit patients into the program.

Lessons Learned

- Not every patient is a good candidate for a Community Paramedicine program. Less motivated patients may need more intensive services or linkages.
- Each patient has their own story – let them tell it. This promotes engagement.
- Engaging the patient through home visits may also engage those around them to be more supportive. For example, an elderly patient without any family may soon find their neighbors taking notice of their well-being now that they see the Community Paramedics are coming by to check on them.
- Use of appointment cards is an effective way to remind and engage the patients in their upcoming visits.
- Developing relationships with your patients is key. This takes time, effort, and patience, and is critical to gaining the patient's trust.



- [EUROQOL, PAM, and GAIN](#)
- [Abbeville's Patient Canceled Appointment Tool](#)

Program Discharge

The intent of a Community Paramedicine program is not to keep patients continuously enrolled in services. Ideally, the Community Paramedics should be able to connect the patient to the physical, medical, and possibly even emotional resources he or she needs and to follow up as recommended by their physician. Therefore, Community Paramedicine programs should consider what a “discharge” from their program might look like and how it would be operationalized. One planned approach is for the Community Paramedic to make a recommendation to the medical control physician that a patient is ready to be discharged. If the medical control physician agrees, then the patient would be placed on an “inactive” patient list and would receive follow up visits on at least a quarterly basis. (More often if dictated by the physician.) If the patient has an unscheduled care event, such as an Emergency Department visit for a non-emergent, chronic disease related issue, the patient would be automatically re-enrolled into the program.

Since this process has not been implemented in South Carolina yet, there are no “lessons learned” or “resources” to be shared... stay tuned for updates!

Program Evaluation

The most difficult step in implementing your Community Paramedicine program is evaluating what you have done. How do you know that you have improved patient outcomes or saved costs? The first step in any good program evaluation is to make sure you are asking the right question. Go back to the beginning of your journey and think about the one single problem you wanted to solve. Maybe it was too many non-emergent 911 calls. Your question then is, did using Community Paramedics in my community reduce the number of non-emergent calls? Once you have your question, you will want to consider putting an evaluation plan into place.

Evaluation Plan Steps

1. Develop your team.
 - a. Who will lead it? Will he or she be internal or external to your operations?
 - b. Which of your other partners need to be involved in this team?
2. Define your audience.
 - a. Who will be reviewing your work? County council? A local hospital administrator? A staff person from the Medicaid agency? What does he or she care about most?
 - b. How will you present your data to your audience in a way that it is well-received, regardless of the outcome?
3. Outline your plan.
 - a. How is your desired outcome related to each of the steps you took to get to that outcome? (Use a Logic Model to help you visualize this.)
 - b. Which of those specific steps can you measure?
 - c. What is your timeline for measuring your outcome?
4. Determine where you will get your data.
 - a. Will you use your ePCR to collect data on home or community visits?
 - b. How will you get data from your other partners? Do you need to have data sharing agreements in place?
5. Put your plan into action.
 - a. Collect data at regular intervals and review outcomes with your team. Consider using “scorecards” to track most critical measures.
 - b. Stick to your timelines to the best of your ability and be prepared when it is time to develop your final report.

An evaluation is different from your internal quality assurance processes. While you still need to do QA on your Community Paramedic calls to detect and correct deficiencies in care, much like you would do for your regular service, an evaluation is a necessary next step to ensure you can document your overall program success or failure. Since Community Paramedicine programs are new, it is up to all of us to collect and document as many outcomes as we can to build an evidence-base for them.

An evaluation is also necessarily different from “telling your story”. This is covered in the Program Branding section.

The EMS Performance Improvement Center is currently working with programs in North and South Carolina to develop common measures for data collection in Community Paramedicine programs. This

effort will provide a more robust evidence base for the future as well as promote the incorporation of measures into the Patient Care Report systems.

Lessons Learned

- Avoid the “kitchen sink” mentality of program evaluation. Even though it is tempting, you will not have the time or resources to measure every single thing you want.
- Data sharing agreements are very important and take time, especially with large organizations such as your local hospital.
- Ensure you have Community Paramedic program patient consent forms in place that cover sharing Protected Health Information with other organizations for care coordination as well as for program evaluation.
- Universities are good resources for experienced public health evaluators; however, engaging a researcher may take lots of time. Look into public health or social work programs that have internship requirements – students are often eager to get “real world” experience and may be available to work for free. You may also connect with an instructor at a local community college who has an interest and could work with you on this part of your program.
- It is easy to put off evaluation planning until later in your program development phases. It is better to define what you want to get out of the program early in order to help you focus your resources along the way.
- Take time to conceptualize how data will need to move between your agency and the other providers you are working with, especially large organizations such as your local hospital, or organizations that may not have electronic health records such as a free medical clinic. Not only will data need to flow between entities for purposes of patient care but also for the program evaluation.



Resources

- [CDC Logic Model Example](#)
- [Community Paramedicine Evaluation Tool](#)

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Appendix A Abbeville Community Paramedicine News Articles

- 1) [South Carolina Hospital Association](http://www.scha.org/news/abbeville-launches-unique-program-to-reduce-readmissions). *"Abbeville Launches Unique Program to Reduce Readmissions"*. October 22, 2013. Accessed on October 22, 2013:
<http://www.scha.org/news/abbeville-launches-unique-program-to-reduce-readmissions>

- 2) [News Article from Greenwood, South Carolina](#). *"Bridging the Health Care Gap"*. Written by Frank Bumb. Accessed on November 18, 2013.

Oct. 22, 2013



Rural Critical Access Hospital Abbeville Area Medical Center (AAMC) and Abbeville County EMS (ACEMS) have joined forces to create a unique program in their corner of the state – a community health care service designed to reduce avoidable readmissions and unnecessary safety net ER use by focusing on home-based preventive care.

“Traditionally EMS has been emergency-driven,” said David Porter, ACEMS director. “Now we’re talking about being a little more proactive on the front end.”

Porter is working closely with AAMC Chief Quality Risk Officer Mary Margaret Jackson, CPHQ and Medical Director Keith Scott, MD to plan and implement the new program. They hope to reduce emergency department visits by 20 percent over the next two years.

ACEMS will check on patients (as requested by physician order), support them in better self-management of their chronic conditions and help them to access crucial resources. The team may also do home safety checks. For instance, they might make sure there is food in a diabetic’s refrigerator or determine a patient needs a smoke detector and figure out how to get one donated for him.

This type of pre-emptive care can absolutely prevent the overuse of emergency services.

“Community paramedics (CPs) are able to act as a physician’s eyes and ears regarding the everyday environmental and social factors present in patients’ lives,” said Porter. “This is critical because these factors can greatly impact disease processes.”

Along with easing the burden for hospitals, more responsibility and an increased capacity to assist vulnerable patients may also help boost job satisfaction and reduce turnover among EMS staff who become CPs.

Eventually the techs hope to work in visits to individuals who experience difficulty accessing care due to socio-economic status. These patients may not have reliable transportation or family support, or may lack the literacy level necessary to complete basic forms.

To help tackle readmissions among patients identified as “frequent users”, ACEMS will arrange a home visit soon after discharge, where the community paramedic will be able to help clarify physician orders, go over medication lists and compliance or address other needs with the patient and family members.

Porter acknowledged this expanded role in patient care will be a new experience for his agency. “It’s not what paramedics have typically concentrated on. It’s a different mindset,” he said.

They have been well trained for the challenge. Three ACEMS community paramedics recently traveled to Fort Worth, Texas for ride alongs and immersion with the “boots on the ground” of MedStar Mobile Healthcare. Medstar developed a robust Community Health Program in 2009 and subsequently saved \$3.3 million in health care expenditures and decreased targeted 9-1-1 usage by more than 86 percent.



Paramedicine models have also been launched in North Carolina, Colorado and Minnesota. Colorado’s successful Western Eagle County [program](#) in particular served as a model for the Abbeville team.

The three levels of training necessary to become a CP include a 15-week didactic college-level course, hands-on lab sessions and 100 hours of clinical rotations.

The overall goal of the course is to broaden understanding of the health care system and local community with a focus on how the CP’s role can best integrate into both.

Initial planning for Abbeville’s service began in 2012 when ACEMS received a training [grant](#) from the SC Office of Rural Health (SCORH). The motivations for SCORH were to increase access to health care and deal with the many challenges of an aging population.

“Community paramedics are well-positioned to have a demonstrative impact on the primary care services available to the safety net community in rural areas of our state,” said Melinda Merrell, director of quality & hospital programs for the SCORH. “This innovation in bolstering existing resources to fill gaps in access to care is an excellent example of how small and rural communities are putting the [Triple Aim](#) into practice.”



The program also recently secured a substantial two-year [grant](#) from the Duke Endowment. Project leaders will continue to seek additional sustainability funding.

ACEMS has formed relationships with numerous regional agencies to build and strengthen the program, including the Abbeville Family Medicine Associates (a Rural Health Clinic), Welvista, the Area Agency on Aging, United Christian Ministries and even the local Rotary club.

Porter envisions a compassionate and cost-saving system where ACEMS CPs have the opportunity to establish a strong regional network and teach at-risk residents how to take better care of themselves.

“We’re not trying to do it all...and we can’t be the best at everything,” he explained. “But what we can do is efficiently deliver helpful community resources to patients when they need them the most.”

Bridging the health care gap

Abbeville Community Paramedic program helps people who fall through system's cracks

By FRANK BUMB
fbumb@independentjournal.com

ABBEVILLE — A new, cutting-edge initiative has Abbeville County paramedics rethinking how they provide assistance to area residents.

Spearheaded by Emergency Management Director David Porter, the program has paramedics evolving into community paramedics.

"They're not doing anything that

a paramedic isn't currently licensed to do in South Carolina," Porter said. "But they are doing things that paramedics have not traditionally done. So they are doing an expanded role."

While Porter played down the transition for his paramedics, the program is the first of its kind in South Carolina. Mary Margaret Jackson, chief quality and risk officer for the Abbeville Area Medical Center, said the program repre-

sents a radical shift in thinking for health care.

"We can't sit on our laurels anymore and wait on patients to come and see us and take care of them and then dismiss them from the building and that's all we do," Jackson said.

That expanded role is a focus on preventative care, emphasizing in-home visits for people battling

See GAP, page 4A

GAP

—Continued from JA

chronic illnesses such as chronic obstructive pulmonary disease (COPD), congestive heart failure, high blood pressure and diabetes.

Funded through a \$25,000 grant from the South Carolina Office of Rural Health and a \$153,000 grant from the Duke Endowment, the program shifts paramedics into a preventative — instead of reactive — force.

"The goal isn't to prevent that 911 call," Porter said. "It's to prevent the traumatic event that leads to that call, especially with chronic illnesses where education can play a role."

The changing face of medicine makes it difficult for professionals to keep up. For a layman, it is almost impossible to accurately and efficiently work through treatment.

"You know, you go into the (emergency room), they diagnose you with diabetes and they give you a stack of papers this thick and you don't really understand it," Porter said. "Our goal is to help bridge that gap of understanding to help you manage your illness."

Building bridges through education is an important part of the community paramedics' job. Instead of just telling a patient what and how to manage their illness, the lessons will also include the "why."

"We want you to understand if you have a congestive heart condition that when you go to the grocery, you understand that you need the low-sodium chicken noodle soup," Porter said. "And when you understand the 'why,' you know what you need in your entire grocery cart."

Another facet of the program is acting as a bridge between local wellness groups.

"If you're having trouble getting up and down your steps, maybe we can pair you up with a church group that can get you railing or maybe a lift or something," Porter said. "For a lot of people, navigating these things is tough. But the Community Paramedics know who to call at the United Way, at the (United Christian Ministries of Abbeville County)."

"Those pairings for patients in the program start the program," Porter said. "This program will grow, but, right now, we have to stick to our criteria."

Part of the limited number of patients — two additions per week with an initial goal of 100 total patients — is because of the intensive data analysis being undertaken. Observers from the University of South Carolina, the South Carolina Office of Rural Health and the Duke

Endowment will all be tracking the program's progress.

"This program could definitely be instituted across the state," Jackson said.

The training for the program includes more than 200 hours of clinical and didactic training as well as 40 hours shadowing a similar program in Fort Worth, Texas.

Porter repeatedly credited Deputy Director William Blackwell with leading the training of the community paramedic program. Porter also pointed to the support of the Abbeville County Council and Abbeville County Director Bruce Cooley in supporting the program.

That support made the program exciting for the boots on the ground in Abbeville County medical care.

Eric Livingston has eight years as a paramedic with Abbeville County Emergency Management. Porter said Livingston's response to the proposed initiative was pure enthusiasm.

"When I heard about that, I went straight to David's office and said, 'I want in on that,'" Livingston said. "It's something that's changing the face of medical care across the country. I think people will really like the results as we expand this program."

Appendix B Introduction to Community Paramedicine

- 1) [National Association of Emergency Medical Technicians: 2012 Study](#)
- 2) [Western Eagle County Health Services District](#)
- 3) [Minnesota Ambulance Association Community Paramedic](#)
- 4) [MedStar](#)
- 5) [Wake County EMS- Advanced Practice Paramedics](#)
- 6) [International Community Paramedicine Models](#)
- 7) [Australia](#)
- 8) [Canada](#)



Dear Members,

Last summer, we asked you to participate in a survey about community paramedicine (CP) and mobile integrated healthcare (MIHC). The survey was conducted to help everyone in EMS better understand these trends, and to develop strategies and policies to support it.

At this time, we are pleased to provide you with a summary of the responses to this survey.

Community Paramedicine/Mobile Integrated Healthcare Survey Summary

As an additional resource, an interactive map has been created of all community paramedicine and mobile integrated healthcare programs reported through the survey.

CP/MIHC online interactive map

The NAEMT Board of Directors, with the assistance of NAEMT's Community Paramedicine/Mobile Integrated Healthcare Committee, will continue to explore this issue and share pertinent information with our members. You can learn about this subject by visiting the **Community Paramedicine and Mobile Integrated Healthcare** page on NAEMT's web site.

We hope you find this information useful. As always, thank you very much for your continued support of NAEMT and the EMS profession.

Sincerely,

Don Lundy, NREMT-P
President, NAEMT

Eagle County Paramedic Services (Western Eagle County Health Services District)

Eagle County Paramedic Services, formerly known as WECAD, serves the residents of Eagle County, CO. The goal of their Community Paramedic program is to:

- "Improve health outcomes among medically vulnerable populations;" and
- "Save healthcare dollars by preventing unnecessary ambulance transports, emergency department visits, and hospital readmissions".

Additionally, WECAD identified two components for their Community Paramedic Model; these are, primary care services and community-based prevention services. The primary care services consists of a physician's order for primary care that is conducted in the patient's home by a Community Paramedic. Also, with help from the local public health department community based prevention services are available through the Community Paramedics. All the services provided by WECAD's Community Paramedics were within their EMS scope of practice. While some Community Paramedicine programs might try to expand their paramedic's scope of practice, mainly seen internationally, it is extremely beneficial to expand the paramedic's role via Community Paramedic instead of attempting to expand the paramedic's scope of practice.²²

- Western Eagle County Health Services District and the North Central EMS Institute developed a *Community Paramedic Program Handbook*. This book can be downloaded at: <http://www.communityparamedic.org/ProgramHandbook.aspx>.
- Website: <http://eaglecountyparamedics.com/>

Minnesota Ambulance Association Community Paramedic

Like the WECAD Community Paramedic model, the Minnesota Community Paramedic program also states that an effective Community Paramedic program supports the Triple Aim; "the best care for the whole population at the lowest cost". Over the past decade Minnesota has been working to fill the gaps in healthcare services in both urban and rural environments. July 1, 2012 was the effective date for their Community Paramedicine reimbursement legislation. The Minnesota Community Paramedic program stated that "the state law legitimizes Community Paramedic as a legally recognized, clearly identifiable, valuable member of the healthcare delivery system". Their Community Paramedics act in an expanded role, but within their scope of practice.²³

- Minnesota Ambulance Association Community Paramedics and Buck McAlpin developed an "Implementing an Effective CP Program" document. This document can be downloaded at: <http://www.mnruralhealth.org/documents/pdf/CP%20Implementation%20final.pdf>.
- Reimbursement: Gathering of Eagles, 2013. *Why and How Minnesota is Implementing Community Paramedic Services*. The Minnesota Community Paramedic Initiative. gatheringofeagles.us/2013/Saturday/Conterato-CP.pdf

²² Western Eagle county Health Services District. Community Paramedic Program Handbook. Fall 2011 Version 1.2.

²³ McAlpin, B. *Implementing an Effective CP Program*. Minnesota Ambulance Association Community Paramedic.

MedStar

MedStar in Fort Worth, Texas is currently serving more than 880,000 people. Medstar stated that the goal for their EMS Mobile Healthcare Program is to achieve Triple Aim; which is, improve patient experience and patient care while reducing per-captia costs. The EMS provider MedStar, has several programs that are centered around patient navigation and Mobile Intergrated Healthcare. These are:

- 911 Nurse Triage
- EMS Loyalty Program
- CHF Readmission Avoidance
- Hospice Revocation Avoidance
- Observational Admission Avoidance.²⁴

To find more information regarding MedStar and their programs please go to their website at:

<http://www.medstar911.org/>

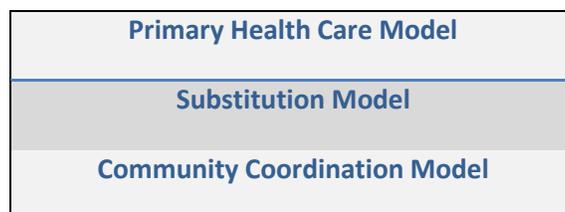
Wake County EMS - Advanced Practice Paramedics

In hopes of "adding a new and efficient enhancement" to their existing Wake County EMS model, their service implemented an Advance Practice Paramedic in January, 2009²⁵.

- Website:
<http://www.wakegov.com/ems/about/staff/Pages/advancedpracticeparamedics.aspx>
- Video on Wake's Advanced Practice Paramedic Program (APP):
http://wake.granicus.com/MediaPlayer.php?publish_id=221

International Community Paramedicine Models

International Community Paramedicine programs differ slightly from Community Paramedicine programs in the US. The Council of Ambulance Authorities (CAA) identified three EMS models that were developed and executed in rural and very rural areas; these are²⁶:



²⁴ MedStar: Mobile Healthcare Programs-Overview. Accessed on November 26, 2013: <http://www.medstar911.org/community-health-program>.

²⁵ Advanced Practice Paramedics. Wake County EMS. Accessed on November 29, 2013 at <http://www.wakegov.com/ems/about/staff/Pages/advancedpracticeparamedics.aspx>

²⁶ Blacker, N., Pearson, L. Walker, T. Redesigning paramedic models of care to meet rural and remote community need. Council of Ambulance Authorities and Ambulance Victoria: http://ruralhealth.org.au/10thNRHC/10thnrhc.ruralhealth.org.au/papers/docs/Blacker_Natalie_D4.pdf

Primary Health Care Model

CAA defines the Primary Health Care Model as an "integration of health services in partnership with other health professionals, extended access to primary health services and to promote disease and injury prevention while continuing to provide pre-hospital emergency care". The *Ambulance Service of New South Wales* (ASNSW) and *Queensland Ambulance Service* (QAS) are examples of the international Primary Health Care Model as defined from the Council of Ambulance Authorities. These programs differ in the respect that the ASNSW program is geared towards a metropolitan area and the QAS program is geared towards rural and remote areas; however, the main focus of both of these models is on extended treatment and referrals.²⁷

The Community Referrals (CREMS) program in *Ontario* allows Community Paramedics to make referrals to the Community Care Access Center; the referral has to be on the behalf of the patient and with their consent. The CREMS program follows the Primary Health Care Model of pre-emergency care and referral. CREMS identified that most of their calls were low-acuity, non-emergency calls that needed primary care or additional help accessing other community services. Thus, Toronto EMS developed the Community Paramedicine program so that paramedics could address the growing number of paramedic responses.²⁸

Substitution Model

The substitution model uses EMS personnel "in hospital emergency departments as either a substitution for General Practitioners or Nurses" as described by the CAA. An example of the substitution model is the *St. John Northern Territory* ambulance service. This model expands the scope of practice of paramedics and ensures that communities have appropriate levels of healthcare coverage in the community.²⁵

The *Nova Scotia* Community Paramedic program is using a substitution model as well. These Community Paramedics are being placed in an isolated location, the island of Long and Brier, to establish 24/7 emergency medical coverage on the island. Nova Scotia EMS states that "when the paramedics are not busy with emergency calls, they provide non-emergent health care and will be working jointly with a Nurse Practitioner and an offsite Physician". The Community Paramedics' duties include administering flu shots, holding clinics, and checking blood pressures. Also, non-emergent phone calls for services are included in the role of the Nova Scotia Community Paramedics. These include: Diabetic Assessments; Wound Care; Drawing Blood for Lab Tests; Congestive Heart Failure Assessment; Administration of Antibiotics; Urinalysis Assessment; Suture Staple Removal; Medical Compliance; and Educational Sessions. The educational sessions include fall prevention, first aid, CPR, infant child seat installation, and bicycle helmet safety.²⁶

Community Coordination Model

Lastly, the community coordination model uses EMS personnel "in coordinator roles primarily aimed at supporting ambulance volunteers while providing the community with additional health services as required".

An example of a Community Coordination Model from the Council of Ambulance Authorities (CAA) is the *Ambulance Victoria*. This model focuses on recruiting, retaining and providing support to existing health services when needed. Additionally, a more "traditional" Community Paramedic role in Australia is the *St John Western Australia* ambulance service; activities include assisting local healthcare entities in meeting the demand for services, assisting hospital staff in the absence of other medical providers and providing a point of access for the community when no other medical providers are available.²⁵

²⁷ Blacker, N., Pearson, L. Walker, T. Redesigning paramedic models of care to meet rural and remote community need. Council of Ambulance Authorities and Ambulance Victoria: http://ruralhealth.org.au/10thNRHC/10thnrhc.ruralhealth.org.au/papers/docs/Blacker_Natalie_D4.pdf

²⁸ Nolan, C., Hillier, T. D'Angelo, C., Community Paramedicine in Canada. Emergency Medical Chiefs of Canada: <http://www.nasemso.org/Projects/RuralEMS/documents/CommunityParamedicineCanada.pdf>

Other International Models

Australia

In Australia, a well-placed EMS health care professional(s) can enhance and contribute to sustainability of Community Paramedicine Programs. They are a key stakeholder in improving the health outcomes of not only more urban locations but rural to very rural areas in Australia.²⁹

- For a more in depth look at the "Matrix of rural and remote specific paramedic role developments", please see the *Redesigning paramedic models of care to meet rural and remote community needs* from the Council of Ambulance Authorities at:
http://ruralhealth.org.au/10thNRHC/10thnrhc.ruralhealth.org.au/papers/docs/Blacker_Natalie_D4.pdf

Canada

In Canada, EMS is placed at the center of the community, providing primary health care services in a mobile environment. Canada EMS validates collaboration with community healthcare stakeholders to enable innovative initiatives that will improve healthcare within a community.³⁰

- To get more information from the Emergency Medical Services Chiefs of Canada, please see *Community Paramedicine in Canada* at:
<http://www.nasemso.org/Projects/RuralEMS/documents/CommunityParamedicineCanada.pdf>

²⁹ Blacker, N., Pearson, L. Walker, T. Redesigning paramedic models of care to meet rural and remote community need. Council of Ambulance Authorities and Ambulance Victoria: http://ruralhealth.org.au/10thNRHC/10thnrhc.ruralhealth.org.au/papers/docs/Blacker_Natalie_D4.pdf

³⁰ Nolan, C., Hillier, T. D'Angelo, C., Community Paramedicine in Canada. Emergency Medical Chiefs of Canada:
<http://www.nasemso.org/Projects/RuralEMS/documents/CommunityParamedicineCanada.pdf>

Appendix C Conceptualizing a Community Paramedicine Program

- 1) [CP Advisory Committee Example](#)
- 2) [Abbeville's Stakeholder/Partner List](#)

* This is a preliminary list for creating a Community Paramedicine Advisory Committee (from an EMS service’s perspective). You will need to expand this advisory list to reflect your community’s resources.

Community Paramedicine Advisory Committee Example:

- County Council Representative
- County Health Coalition Representative
- Nursing Home Representative
- Home Health Representative
- Hospital Representative
- Free Medical Clinic Representative

* This is an example of Abbeville’s main partners for their Community Paramedicine program and the roles they serve. Please adjust accordingly to your community.

Abbeville’s Community Paramedicine Partner List:

Partner	Role
SCDHEC Division of EMS & Trauma	Regulatory
Abbeville County Emergency Medical Services	EMS
Abbeville Area Medical Center	Hospital
South Carolina Office of Rural Health	Convener/Technical Assistance
The Duke Endowment	Funding
South Carolina Rural Health Research Center	Evaluation

Appendix D Identifying Needs In the Community

- 1) [Need: Abbeville County, SC](#)
- 2) [SCORH's Needs and Primary Care Assessment Description](#)
- 3) [Community Assets Map: Example 1](#)
- 4) [Community Assets Map: Example 2](#)

Community Paramedicine Needs Assessment

Abbeville County, SC – September 2012

Public Health Need:

Table 1. Demographic Characteristics						
	<i>Total Population, 2010¹</i>	<i>African American, 2010¹</i>	<i>Adults 25+ less than HS, 2010¹</i>	<i>Population in Poverty, 2010²</i>	<i>Unemployment rate, SC DEW, June 2012</i>	<i>Adults 18 - 64 without health insurance³</i>
<i>Abbeville</i>	25,417	28.3%	23.2%	19.7%	11.3%	23.2%
<i>South Carolina</i>	4,625,364	28.2%	17.0%	17.1%	9.4%	23.1%

Table 2. Chronic Disease Risk Factor Prevalence - 2010 DHEC County Profiles					
	<i>Current smoking</i>	<i>Sedentary lifestyle</i>	<i>Overweight</i>	<i>High Cholesterol</i>	<i>Hypertension</i>
<i>Abbeville</i>	18%	24%	78%	31%	45%
<i>South Carolina</i>	21%	21%	67%	42%	35%

Table 3. Chronic Disease Mortality Age-Adjusted Rates (per 100,000) - 2010 DHEC County Profiles				
	<i>Heart Disease</i>	<i>Stroke</i>	<i>Diabetes</i>	<i>COPD</i>
<i>Abbeville</i>	197.5	61.2	29	73.2
<i>South Carolina</i>	188.9	47.7	22.5	46.2

Table 4. Chronic Disease ED Utilization Rates (per 100,000) - 2010 DHEC County Profiles				
	<i>Heart Disease</i>	<i>Stroke</i>	<i>Diabetes</i>	<i>COPD</i>
<i>Abbeville</i>	562	219	355	1701
<i>South Carolina</i>	371	94	291	982

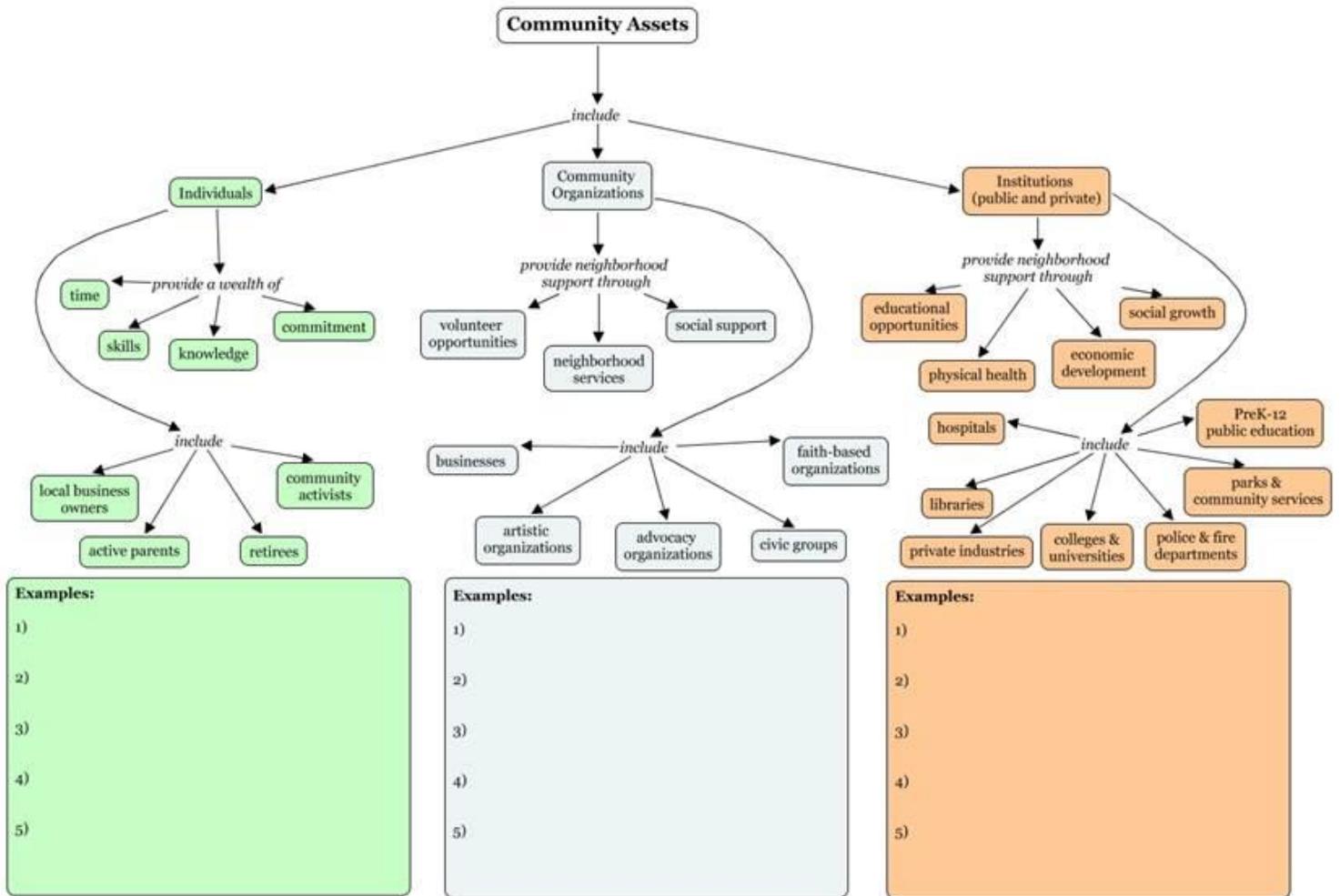
Table 5. Emotional Well-Being & Overall Mental Health Indicators - 2008-2010 BRFSS			
	<i>One or more days poor physical health in past month</i>	<i>One or more days poor mental health in past month</i>	<i>One or more days disabled for physical or mental reasons in last month</i>
<i>Abbeville</i>	24.4%	37.1%	46.1%

The South Carolina Office of Rural Health (SCORH) can compile a Needs Assessment for Primary Care and Specialty Care Physicians for rural counties in South Carolina. Specifically, the Needs Assessment for your county will:

- Determine the need for primary care physicians;
- Determine primary medical service area and population;
- Estimate primary and specialty care physician office visits; and
- Estimate the total demand for primary and specialty care physicians in the medical service area.

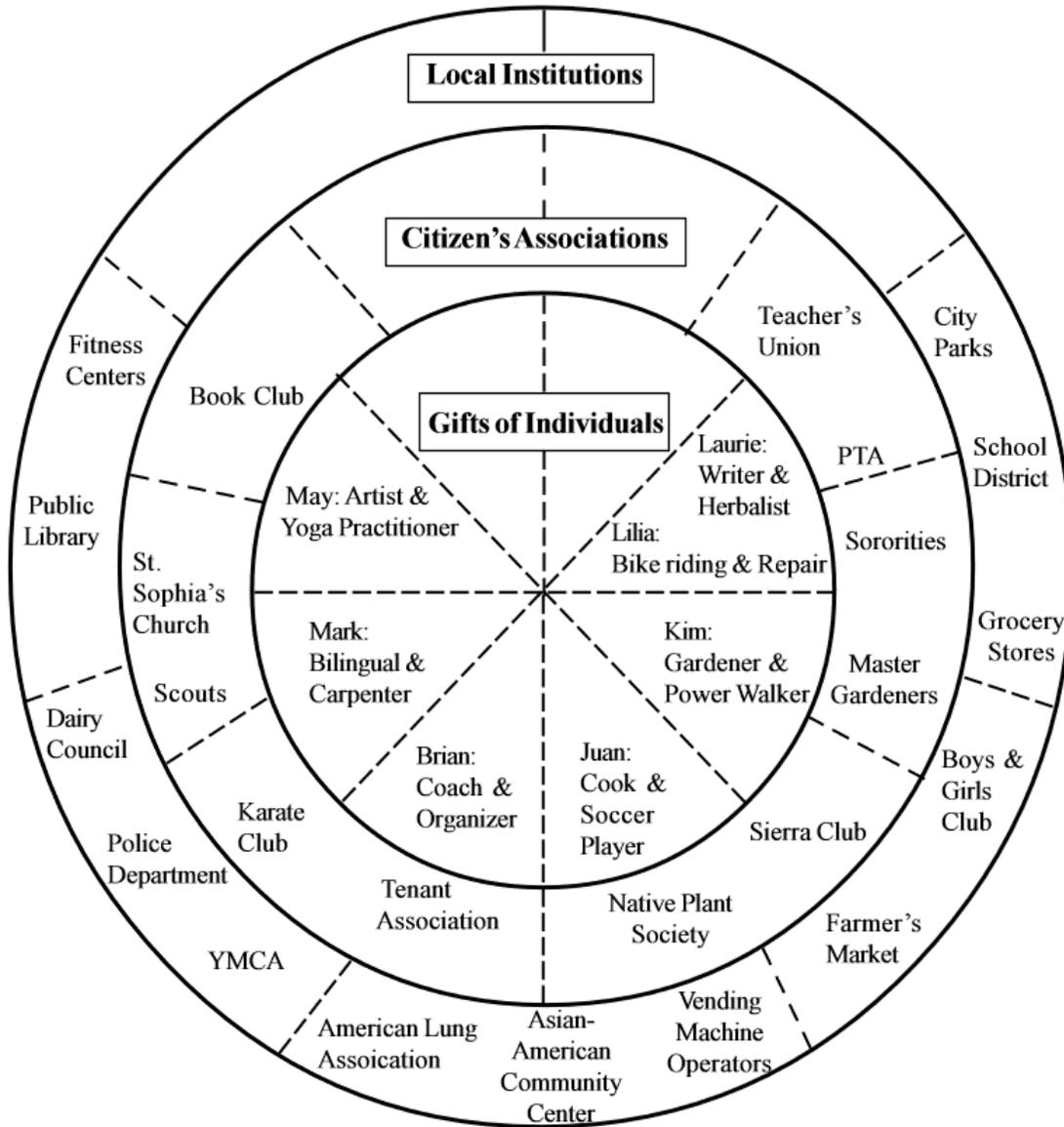
Additionally, SCORH's Needs Assessment will highlight population growth or decline over the past couple of years. Please contact Sarah Mathis at Mathis@scorh.net for more information on SCORH's Needs Assessment.

Community Assets Map: Example 1



Vosoughi, V., Monroe, H. *Neighborhood Asset Mapping: Moving Toward Convergence*. Florida Institute of Education at the University of North Florida.
<http://www.unf.edu/uploadedFiles/aa/fie/NO3Asset%20Mapping.pdf>.

Community Assets Map



Developed by
Center for Collaborative Planning
www.connectccp.org

Center for Collaborative Planning. *Community Assets Map*. Resource Library:
<http://www.connectccp.org/library/title/abcd-asset-based-community-development>.

Appendix E Identifying Potential Partners

- 1) [Draft Support Letter: Example 1](#)
- 2) [Support Letter: Example 2](#)
- 3) [Support Letter: Example 3](#)
- 4) [Abbeville County Resources](#)
- 5) [Community Paramedicine Resource List](#)

South Carolina Office of Rural Health

107 Saluda Pointe Drive
Lexington, SC 29072
Tel 803-454-3850 ~ Fax 803-454-3860
www.scorh.net

December 2, 2013

Jane Doe
Position
Name/Office/Department
111 Address Here
County, State Zip

Dear Ms. Jane Doe:

As (your position here) for (where you work), I would like to express my support and willingness to participate in the development of (what you are interested in developing: program/initiative) here in (area- if it applies). (Explain here why you want to be involved). I am excited at the prospect of (what are you excited about).

(Concluding sentence)

Sincerely,

(Sign your name)

Your Name
(Position)

Support Letter: Example 2



HUMBOLDT GENERAL EMS/RESCUE

118 E. Haskell Street • Winnemucca, Nevada 89445

Phone 775.623.5222 ext. 260 • Fax 775.625.8541

Pat Songer – Director of EMS

Thursday, February 09, 2012

Dear Colleague,

Humboldt General Hospital Emergency Medical Services Rescue (Winnemucca, NV) will host a Community Paramedicine Stakeholders Meeting from 8:30 a.m. to 4:30 p.m. Tuesday, March 27. Humboldt General Hospital will facilitate the daylong event which will include guest speakers from a number of diverse backgrounds. These speakers are all well-known experts in the field of EMS, public health, health care finance and Community Paramedicine. The meeting will help to introduce and explain the emerging field of Community Paramedicine, and how this new program is sure to impact both the economic and physical health of our communities.

Emergency Medical Services serves an important role in ensuring the safety and health of our community members. As you know, the traditional role of EMS is based around the principle of emergent care during a life-threatening emergency. EMS providers are called into a patient's life by activating the 9-1-1 system. However, the number of true emergencies is dwindling due to several factors including increased health disparities, shortages of primary care physicians and the proliferation of a number of chronic diseases. According to a recent study, nearly 40 percent of 9-1-1 calls can be characterized as non-emergent. Due to the fact that EMS systems are often left with no other options, EMS providers are forced to transport patients to hospitals despite there being no true need. This results in more hospital admissions, longer Emergency Department wait times and an overall draining of health care resources.

Community Paramedicine uses evidence-based practices to provide community members a more beneficial health care experience. Community Paramedics provide a cost-effective manner for some patients to receive care for certain ailments. Community Paramedics work with patients to refer them to their primary care providers if a complaint warrants an office visit, and/or provide in-home care when a hospital admission is not needed. Because Community Paramedicine is a relatively new concept, many questions arise when discussing the role of these nontraditional paramedic-level providers. For instance, what is the impact on health care dollars and patient outcomes? How many illnesses and injuries could be prevented if paramedics in our community took a more proactive approach to health? Would there be a decrease in unnecessary hospital readmissions? These are just a few of the important questions being posed by health care professionals, policy makers, patients and the public in communities where Community Paramedicine programs are being piloted.

Community Paramedicine is an innovative way to address a number of health-related concerns within our communities. By using existing EMS providers and systems, Community Paramedics are able to increase access to primary care providers, proactively convey the importance of preventive care, decrease Emergency Department overcrowding, save health care dollars, and improve the overall health and wellness of our patients. For further inquiry into this groundbreaking movement in health care, I would refer you to the following electronic resources: www.dphhs.mt.gov/ems/cp/DiscussionPaper.pdf, www.communityparamedic.org or www.ircp.org.

Given your expertise and involvement in our local community, I would like to invite you (or a designee) to Humboldt General Hospital's Community Paramedicine Stakeholders Meeting at 8:30 a.m. Tuesday, March 27. I am certain that you will be impressed by our expert speakers and the potential of this innovative program. Your participation is very important. Please RSVP by contacting me directly. Should you have any further questions regarding the Stakeholders Meeting or the Community Paramedicine program at Humboldt General Hospital, please feel free to contact me.

Professionally,

A handwritten signature in black ink, appearing to read "Pat Songer".

Pat Songer, NREMT-P
Director, HGHEMS/Rescue
(775) 304-0416

www.hghospital.ws
psonger@hghospital.ws

Support Letter: Example 3

Greetings everyone,

This has been an exciting year for Ada County Paramedics and the EMS profession. I am excited to say we are moving forward with our Community Paramedic initiative as introduced earlier this year as one of many potential solutions to health care reform. We are promoting up to 4 of our paramedics to work half of their time on this new program. These individuals will be instrumental in building the program from the ground up. We are planning a stakeholder's meeting for November 10th. We will be bringing in national speakers to discuss their Community Paramedic Programs and how we can best serve the Treasure Valley. Nothing is set in stone and we are holding this meeting to garner your additional input and further our partnership to help serve our communities as effectively and efficiently as we can. It will take time to plan, develop, and implement. Now is the time to have these discussions to best serve the needs of health care, public health, and public safety. I sincerely appreciate your input to date and your shared enthusiasm to roll out Community Paramedics here in the Treasure Valley.

The meeting is open to anyone wanting to attend. Feel free to forward or invite others who may be interested. A more detailed agenda will be sent in the coming few weeks. I sincerely hope you or your representatives can come to all or a part of this workshop.

Additional information about community paramedic programs can be found at www.communityparamedic.org or www.ircp.info

I look forward to seeing all of you on November 10th. Please RSVP if you can by acknowledging this invite.

Sincerely,

Troy

Troy M. Hagen, MBA, Paramedic

Director, Ada County Paramedics

Boise, Idaho

[\(208\)287-2962](tel:(208)287-2962)

thagen@adaweb.net

www.adaparamedics.org

Community Paramedicine Resource List	
International Roundtable on Community Paramedicine	www.ircp.info
North Central EMS Institute	www.ncemsi.org
National Association of Emergency Medical Technicians	www.naemt.org
National Registry of Emergency Medical Technicians	www.nremt.org
National Association of EMS Officials	www.nasemso.org
National Organization of State Offices of Rural Health Discussion Paper on Community Paramedicine	www.nosorh.org/resources/files/community_paramedic_programs.pdf
Journal of Emergency Medical Services	www.jems.com
Community Paramedic Website	www.communityparamedic.org

Abbeville County, South Carolina Health & Human Service Providers, 2011

Abbeville Chamber Members

Bowen Family Eyecare, PA
100 Trinity Street Abbeville SC 29620
(864) 366-2020

Lawson Family Dental Care
308 Washington Street Abbeville SC 29620
(864) 366-5511

Covenant Way
18 Pressly Drive Due West SC 29639
(864) 379-2570

Anderson Skin & Cancer Clinic
200 Carwellyn Road Abbeville SC 29620
(864) 224-7577

Abbeville Area Medical Center
420 Thomson Circle Abbeville SC 29620
(864) 366-3312

Abbeville Nursing Home
83 Thomson Circle Abbeville SC 29620
(864) 366-5122

+ 211

Abbeville County Adult Education
400 Greenville ST
Abbeville, SC 29620
(864) 366-4226

Abbeville County Department of Social Services
903 W Greenwood St.
Abbeville, SC 29620
(864) 366-5638

Abbeville County Office of Emergency Management
Highway 28 Bypass
Abbeville, SC 29260
(864) 366-2400 x228
Abbeville County Sheriff's Office
21 Old Calhoun Falls Rd
Abbeville, SC 29620
Abbeville, SC 29260
(864)366-2400 x 228

Abbeville Count Sheriff's Office
21 Old Calhoun Falls Rd
Abbeville, SC 29620
(864) 446-6000

Abbeville Parks and Recreation Department
404 N Main St.
Abbeville Civic Center
Abbeville, SC 29620
(864) 366-5007
Abbeville Police Department

102 S Main St.
Abbeville, SC 29620
(864) 366-5832

Crossroads Ministries / My Brother's Keeper (Food Pantries)
37 Union Church Rd.
Abbeville, SC 29620
(864) 366-3484

Erskine College
2 Washington St.
Due West, SC 29639
(864) 379-2131

Mental Health America of Abbeville County
200 Brooks St.
Abbeville, SC 29620
(864) 366-0648

South Carolina Department of Health and Environmental Control -
Abbeville County Health Department
905 W Greenwood ST
Abbeville, SC 29620
(864) 366-2131

South Carolina Department of Mental Health - Abbeville Mental
Health Clinic
101 Commercial Dr.
Abbeville, SC 29620
(864) 459-9671

+ SC Access

Ashley Medical Transport Service, Inc. (AMT)
940 Stevenson Rd., Abbeville, SC, 29620

Veterans' Affairs Office
101 Church Street, Abbeville, SC, 29620
Wylie Hall (Assisted Living); The Village (cottages); Carlisle Nursing
Center (skilled nursing facility)
18 Frank Pressly Dr., Due West, SC, 29639

New Hope Residential Care Center (Assisted Living)
704 Anderson St., Calhoun Falls, SC, 29628-1034

Piedmont Agency on Aging (PAOA)
101 Center Street, Abbeville, SC, 29620

Hospice Care of SC, Abbeville County
103 West Pickens Street, Abbeville, SC, 29620

Calhoun Falls Family Practice
535 Jackson Street, Calhoun Falls, SC, 29628

Abbeville Workforce Center
353 Highway 28 Bypass, Abbeville, SC, 29620-4125

Appendix F Outlining Your Program

1) [South Carolina Community Paramedicine Fact Sheet](#)



South Carolina

Community Paramedicine Fact Sheet

What is Community Paramedicine?

- Community Paramedicine is “an organized system of services, based on local need, which are provided by...Paramedics integrated into the local or regional health care system and overseen by emergency and primary care physicians.”¹
- Community Paramedicine represents one of the most progressive evolutions in the delivery of rural community-based healthcare by using Paramedics within their current scope of practice in an expanded role.

What Need is Addressed By Community Paramedicine?

- Weaknesses in South Carolina’s and the nation’s rural health care infrastructure are exacerbated by the persistent shortage of physicians, nurse practitioners and physician assistants that provide primary care for rural residents.
- Community Paramedicine programs allow Paramedics the ability to not only provide acute illness and injury care but to also proactively identify health risks, provide follow-up care to individuals, and monitor the community’s health^{1,2} thereby bolstering the health care infrastructure in small and rural communities.

What are the Benefits of Community Paramedicine?

- Leverages existing local resources to proactively support primary care in rural communities
- Emphasizes coordination and collaboration among all members of the local health care community
- Promotes person-centered health care and establishment of medical homes
- Lowers health care costs and improves access to and quality of health care
- Provides potential financial support for rural EMS agencies from these non-traditional EMS activities

How are Community Paramedics Trained?

- An internationally recognized and standardized curriculum with both didactic instruction and clinical trainings (Community Paramedic Curriculum 3.0) has been developed by the Community Healthcare Emergency Cooperative³.
- Interested students and educational institutions may contact the Cooperative for more information on currently available classes and support.

How are Community Paramedics Certified?

- There is not a distinct certification available for Community Paramedics in South Carolina. Pilot programs to evaluate the need for and effectiveness of this type of certification are in development.
- As the statewide regulatory agency for certification of all EMS personnel, the SC DHEC Division of EMS and Trauma is an integral partner in the pilot program process.

Where Can I Find Out More?

- <http://www.communityparamedic.org/>
- <http://www.nasemso.org/Projects/RuralEMS/documents/CPDiscussionPaper.pdf>
- <http://www.hrsa.gov/ruralhealth/pdf/paramedicevaltool.pdf>

South Carolina Office of Rural Health: info@scorh.net or 803-454-3850

South Carolina Office of
Rural Health 

Appendix G Program Sustainability

Link:

1) South Carolina Health and Human Services. Healthy Outcomes Plan Guidelines

<https://msp.scdhhs.gov/proviso/sites/default/files/Proviso33.34%20HOP%20Guidelines.pdf>

2) South Carolina Foundation Directory, 2010

<http://www.statelibrary.sc.gov/docs/grant/foundation2010.pdf>

Resources:

3) MHCP Provider Manual - Community Paramedic Services

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_177475

4) Giving EMS Flexibility in Transporting Low-Acuity Patients Could Generate Substantial Medicare Savings

<http://communityparamedic.org/Portals/CP/Documents/PW01%20CP%20Programs%20Funding%20Margolis-Staffan-Swayze-Zavadsky.pdf>

5) Budget Example

Community Paramedic Services

Revised: 02-27-2014

Overview

In 2011, the Minnesota legislature enacted into law the new profession of Community Paramedic to meet the health care needs of recipients living in underserved communities.

Eligible Providers

Community paramedics Emergency Medical Technician – Community Paramedic (EMT-CP) (EMT-CP) who:

- Are certified by the Minnesota [Emergency Medical Services Regulatory Board](#) (EMSRB)
- Are employed by an MHCP-enrolled ambulance service
- Have a service scope agreement, based on the paramedic's skills, with the Medical Director of the ambulance service

To obtain a community paramedic Certificate from the EMSRB an applicant must have:

- A current paramedic certification of EMT-P
- Two years of full-time services as an EMT-P
- Graduated from an accredited course

Eligible Recipients

Recipients enrolled in the following MHCP programs are eligible for community paramedic services:

- BB MinnesotaCare Plus One
- JJ MinnesotaCare Basic Plus
- LL MinnesotaCare Basic Plus Two
MinnesotaCare Expanded
- MA Medical Assistance
- NM State-funded Medical Assistance
- RM Refugee
- FF MinnesotaCare Basic Plus

Recipients enrolled in the following programs are **not** eligible for MHCP community paramedic services:

- AC Alternative Care Program
- EH Emergency Medical Assistance
- FP Minnesota Family Planning Program
- HH HIV/AIDS
- IM Institution for Mental Disease
- QM Qualified Medicare Beneficiary

Community paramedics assist in the care of recipients who:

- Receive hospital emergency department services three or more times in four consecutive months within a twelve month period

- Are identified by their primary care provider at risk of nursing home placement
- May require set up of services for discharge from a nursing home or hospital
- May require services to prevent readmission to a nursing home or hospital

Covered Services

Services must be part of the care plan ordered by the recipient's primary care provider (physician, advanced practice registered nurse (APRN) or physician's assistant). The primary care provider consults with the ambulance service's medical director to ensure there is no duplication of services.

Either the primary care provider or the medical director must coordinate the care plan with all local community health providers and the local public health agencies, including home health and waiver services, to avoid duplication of services to the recipient. Services the community paramedic may perform are:

- Health assessments
- Chronic disease monitoring and education
- Medication compliance
- Immunization and vaccinations
- Laboratory specimen collection
- Hospital discharge follow-up care
- Minor medical procedures approved by the ambulance medical director

Non-Covered Services

The following services are not covered:

- Travel time
- Mileage
- Facility fee
- Services related to hospital-acquired conditions or treatments

Documentation Requirements

Keep complete documentation on file. Refer to the [Provider Requirements](#) section for guidelines.

Billing

The MHCP-enrolled medical director of the ambulance service employing the community paramedic must bill the community paramedic services:

- Bill using the 837P
- Use code T1016 with modifier U3
- Place of service is 12 (home)
- Bill in 15 minute increments (one unit = 15 minutes)

More than half the time (eight minutes), must be spent performing the service face-to-face in order to report a unit.

Bill supplies primary to the encounter separately. Supplies used by the community paramedic in direct relationship to the illness or injury are considered incidental to the service and not separately billable to MHCP.

Legal References

[MS 256B.0625, subd. 60](#) (Community Paramedic Services)

[MS 144E.28, subd. 9](#) (Certification of Community Paramedics)

[MS 144E.01, subd. 5f](#) (Emergency Medical Services Regulatory Board)

[+] [Report/Rate this page](#)

PowerPoint: Giving EMS Flexibility

2/5/14

Features of Current Reimbursement System

- Fee-for-Service Payments
 - Medicare Ambulance Fee Schedule
- Payment only for transport
 - Paramedic Intercept in NY
- Emergency Department only destination following 9-1-1 response



Responding to our community's health care needs

Features of Future Reimbursement System

- EMS System Redesign
- Payment System Redesign
 - Payment for assessment and care, NOT limited to transport
 - Payment for alternative destinations
 - Payment for new roles and types of healthcare personnel
 - Recognition for investment in new health information technologies



Responding to our community's health care needs

Features of Future Reimbursement System

- Workforce Development
 - Expanded role for paramedics with additional training (community Paramedicine)
 - Engagement of other health care professionals (RN – Nurse Navigators)
 - Early advanced assessment in the field (current EMS personnel)



Responding to our community's health care needs

Principles for Payment System Redesign

- Balanced triage
 - Prudent layperson definition of emergency
- Patient-centered
 - Patient Choice and Consent
- Integrated
 - Emergency care, primary care, mental health, social needs
- Stakeholder-engaged
 - Tailored strategies for clinical partners
- Payor-aligned
 - Referral to in-network care
- Leverages new health information technologies
 - Exchange of patient records and data



Responding to our community's health care needs

Community Paramedicine Budget Example

* This budget example in no way represents the actual numbers that should be applied in the line items. You *MUST* make this budget applicable to your Community Paramedicine program. Pay particular attention to the highlighted line items in the budget example.

	Year 1 1 FTE	Year 2 2 FTE	Year 3 3 FTE
Payroll Expense	Community Paramedic	Community Paramedic	Community Paramedic
Salaries	75,000	150,000	220,000
FICA	-	-	-
Medicare Tax	1,200	1,800	3,400
State Unemployment	200	300	450
Workers Comp	8,000	8,000	8,000
Retirement	7,500	15,000	25,000
Health Insurance	12,000	24,000	36,000
Overtime	4,500	7,000	12,000
Total Payroll Expense	\$ 108,400	\$ 206,100	\$ 304,850
Operations Expense			
Accounting Fees	-	-	-
Bank Charges	-	-	-
Board Reimbursement	-	-	-
Building Repairs	-	-	-
Communications Equipment	1.00	-	-
Computer Equipment	2.00	-	2
Dues & Subscriptions			
Election Costs	-	-	-
Emergency Reserve (3%)	-	-	-
Gas and Oil	10.00	10.00	10.00
Insurance	25.00	25.00	25.00
Lease Interest	-	-	-
Lease Principal	-	-	-
Legal Fees	-	-	-
Maintenance Contracts			
Medical Direction Fee	-	-	-
Medical Equipment & Supplies	32.00	32.00	32.00
Misc Expenses	-	-	-
Office Supplies & Postage	-	-	-
Public Relations	6.00	6.0	6.0
Telephone	3.60	3.6	3.6
Training (Initial)	5.00	-	-
Training (Medical & EMS Director)	20.00		
Training (Continuing)	-	5,000	5,000
Transport Expense	-	-	-
Travel	5,000	5,000	5,000
Uniform	500	500	500
Utilities	-	-	-
Vehicle Repair & Maintenance	2,500	2,500	2,500
Total Operating Expenses	\$ 8,105	\$ 13,077	\$ 13,079
Capital Expense			
Capital Purchases (Ambulance C	25,800	-	-
Other	12,000	-	-
Construction Fund	-	-	-
Total Capital Expenses	37,800	-	-
Total Expenses	\$ 154,305	\$ 219,177	\$ 317,929

Appendix H Program Components

Identifying Community Paramedicine Personnel

- [Community Paramedicine Job Description](#)
- [South Carolina Paramedic Scope of Practice](#)

Community Paramedic Training

- [CP Clinical Tracking Chronic Disease](#)
- [Abbeville Community Paramedicine Clinical Sites](#)
- [Wake County's Advanced Practice Paramedic Academy Topics and Hours Overview](#)

Identifying Community Paramedicine Medical Control

- [Medical Control Scope of Duties Example](#)

Regulatory Consideration

- [SC DHEC- 1998 EMS Medical Control Manual- Pilot Projects](#)
- [South Carolina Chart of Healthcare Professions](#)

Role of 911 Dispatch Center

Standard Operating Procedures Development

- [South Carolina DHHS- HIPPA Letter](#)
- [Abbeville's Congestive Heart Failure Protocols](#)

Program Branding

- [Abbeville Community Paramedicine Flier](#)
- [Abbeville CP Truck Markup Picture](#)

Visits

- [Initial and Follow Up CP Visits- Flow Charts](#)
- [Abbeville's Draft Initial Home Visit Checklist](#)

Patient Engagement and Patient Satisfaction

- EUROQOL Tool- Website: www.euroqol.org
- Patient Activation Measure (PAM) Tool- Website: <http://www.insigniahealth.com/solutions/patient-activation-measure>
- Global Appraisal of Individual Needs (GAIN) Tool- Website: http://knowledgex.camh.net/amhspecialists/Screening_Assessment/screening/screen_CD_youth/Pages/GSS.aspx
- [Abbeville's Patient Cancelled Appointment Tool](#)

Program Discharge

Community Paramedic Job Description Example

Overview

A Paramedic has certification and/or licensure as a Paramedic and provides advanced-level medical care. A Community Paramedic supports existing health services by providing integrated health services in partnership with other health professionals. He or she also extends access to health services delivery in underserved and general populations, including primary care, public health, disease management, prevention, and wellness.

Requirements

Successful completion of didactic and clinical coursework for Community Paramedics.

Core Duties

- Performs essential functions of a paramedic
- Examines, screens, treats and coordinates health services for patients
- Conducts post-hospital release follow-up care including, but not limited to, monitoring medication, dressing changes, and checking vital signs
- Observes, records, and reports to physician as to patient's conditions and reactions to drugs, treatments, and/or significant incidents
- Conducts patient education, including diabetes prevention/treatment, hypertension, Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), falls assessment, injury evaluation, geriatric frailty visits, and nutrition
- Administers patient care consistent with department protocols and physician orders
- Coordinates appointments and follow-up with physicians and hospitals
- Develops and completes appropriate reports and templates for the Community Paramedic Program
- Attends meetings as requested and available
- Participates in trainings to maintain competencies of Community Paramedic
- Provides training to personnel as requested
- Performs other related functions as assigned

South Carolina Paramedic Skills

SC EMT-PARAMEDIC SKILLS

All EMT-Paramedic candidates who successfully complete a SC approved EMT-Paramedic course which uses the current DOT EMT-Paramedic curriculum, successfully pass the National Registry EMT-Paramedic (i.e. SC State Paramedic written and practical examinations) and receive subsequent SC certification as an EMT-Paramedic are authorized to perform the following skills: (All skills are inclusive of adult and infant unless otherwise stated).

- All skills listed under SC EMT-Basic
- All skills listed under SC EMT-Intermediate
- Endotracheal Intubation
- Medication Administration
 - Sub Q Injection
 - IM Injection
 - IV Push
 - IV Drip
 - Endotracheal Tube
 - Rectal
- Pleural Decompression (Adult & Pediatric)
- Gastric Lavage
- Vagal maneuvers
- EKG Monitoring and Rhythm Identification to include 12-lead (Optional for 12-lead)
- Defibrillation
- Cardioversion
- External Pacing
- Rapid Sequence Induction
- Monitoring approved interfacility drugs
- Managing cardiac patients per current ACLS standards

NOTE: ALL ADDITIONAL SKILLS LISTED ABOVE FOR THE EMT-PARAMEDIC MAY ONLY BE PERFORMED WHEN THE EMT IS AFFILIATED WITH A SC LICENSED AMBULANCE PROVIDER UNDER THE AUTHORITY (ON-LINE OR OFF-LINE) OF THE PROVIDER'S MEDICAL CONTROL PHYSICIAN.

Approved Skills (revised 12/2009)

Abbeville CP Clinical Sites

- Home Health
- Diabetic Education
- Senior Connections
- DME
- Family Medicine
- ED
- Mental Health
- Free Clinic
- NGOs/Community Based Organizations (Ongoing)
 - Area Agency on Aging, United Way, Abbeville County Healthy Coalition, UCMAC
- Emergency Management (Ongoing)

Wake County EMS APP Academy Topics and Hours Overview

WAKE COUNTY EMERGENCY MEDICAL SERVICES APP ACADEMY TOPICS AND HOURS OVERVIEW

Classroom Topics	Hours	Clinical Rotations	Hours
MEDICAL TOPICS			
Advanced Airway Management	4	APP Quality Improvement	8
Fracture Management	2	WakeMed ED (triage)	8
Immunizations	2	Wake County PH Clinics	24
Epidemiology and Bioterror Agents	8	The Healing Place	8
Complications of Diabetes	8	EMS Communications (911)	8
Advanced EKG, STEMI, CHF	8	Cath Lab, Rex Hospital	4
High-risk OB/GYN	3	Case Management, WakeMed	4
Respiratory Emergencies	4		64
Acute Alcoholism and Substance Abuse	8		
PUBLIC HEALTH TOPICS			
Access to Public Health Services	12	TOTALS	
		Classroom	191
		Clinical	64
		TOTAL	255
LEGAL, QI, AND DOCUMENTATION			
APP documentation	2		
EMTALA	3		
High Risk Refusals	3		
QI for the APP	3		
PSYCHIATRIC AND VIOLENT PATIENTS			
Crisis Intervention (CIT/CIP)	32		
Medical Detox	6		
INJURY PREVENTION			
Injury Prevention, general	8		
Home Safety Inspections	6		
Diabetic Care	4		
Hypertension care	4		
OPERATIONS ETC.			
Preplanning and Facility Strategy	3		
Personal Safety	8		
Light vehicle EVOG	8		
INTERPERSONAL AND DECISION-MAKING			
Follow-up and patient call-back	3		
Customer Service	3		
Death Notifications	12		
Dealing with High Risk Refusals	4		
Mentoring and Coaching	2		
Medical Director Meetings and Reviews	18		
	191		

Medical Control Scope of Duties Example

EXHIBIT A SCOPE OF SERVICES

The following services will be performed within the scope of the Community Paramedic Program.

1. Provide clinical supervision of up to 5 Community Paramedics.
2. Provide clinical direction in the development of protocols, policies and procedures.
3. Assist in the ongoing development and implementation of a quality improvement and assurance system.
4. When appropriate, outreach to other physicians to increase the network of medical providers participating in the community paramedic program.
5. Participate on and provide leadership to the Community Paramedic Advisory Committee.
6. Work with Dr. _____ to ensure quality of care and continued oversight.
7. Safeguard protected health information of individuals and the confidentiality of situations for which Physician's consultation is requested, in accordance with the rules of _____ and the Health Information Privacy and Accountability Act.
8. Comply with appropriate standards of customer service to the public and provide appropriate consultation in the development and implementation of Community Paramedic protocols to promote the maintenance of high standards of customer service and professionalism.

F. PILOT PROJECTS

The state EMS Advisory Council has approved several pilot projects for emergency medical services in South Carolina. **Pilot projects which are current are the cricothyrotomy pilot project and the Rapid Sequence Induction pilot project.** Projects which have been conducted in the past include: aspirin treatment for cardiac patients, the Gusto study, the rectal Valium pilot project, the TPA Thrombolytic Therapy project and EMT-Defibrillator. Other projects can be approved by review of the Medical Control Committee and the EMS Advisory Council. The pilot projects, following their successful completion, may be adopted as statewide skills.

Cricothyrotomy pilot project: Airway protection is an immediate concern in the management of a critical patient. Airway protection and maintenance can be difficult in patients who have suffered severe maxillo-facial injuries, cervical spine injuries, or anaphylactic reactions. Many EMS systems around the country have trained their personnel to perform cricothyrotomies. A pilot project has been in effect for Spartanburg County and Meducare to train EMT-P's to perform cricothyrotomies in those cases where an airway cannot be established by the traditional routes.

Rapid Sequence Induction Intubation: (From information in articles provided by Lancaster County EMS in it pilot project application): Although endotracheal intubation is considered the optimal technique for airway management in critically ill patients, performance of this task in the prehospital setting is at time difficult due to increased masseter muscle tone, vocal cord spasm or patient combativeness. Use of short-acting paralyzing agents by paramedics to facilitate intubation in these situations is an uncommon practice. However, previous studies have shown that paramedics can become very proficient in this procedure if properly trained. Succinylcholine has been used nationally for several years with varying success. The goal of systemic medications and applied techniques of RSI is to increase the percentage of successful intubations in the complex, nonfasting airway.

STEPS FOR APPLYING FOR PILOT PROJECT APPROVAL:

The request for approval of a pilot project must be submitted in writing by the director of the emergency medical service, with the signature and approval of the service's medical control physician.

The following requirements must be addressed as separate items in the written request:

1. Brief description of the licensed EMT service
2. Justification of need for the program, including any data available
3. Data on costs and cost effectiveness
4. Description of the equipment and functions
5. Responsibilities of the medical control physician
6. Explain how involved the medical control physician is in this project
7. Name and qualifications of the person assisting the medical control physician with training
8. Outline of the initial curriculum for training
9. Plans and procedures for continuing education
10. Protocols
11. Plans for supervision of activities
12. Record system on pilot project activities, training curriculum, and attendance at training programs
13. Names and qualifications of the EMTs participating in the program
14. Method for evaluation of cases and outcomes
15. Method for handling cases of inappropriate procedures

16. Plans for evaluation of the pilot project after 12 months.

Requests for pilot projects will be considered for approval by the Medical Control Committee. Representatives of the service submitting the request will be invited to attend the meeting.

South Carolina Chart of Healthcare Professions

Profession	License/Certification	Reference
Physician	MD; DO	SC Medical Practice Act: http://www.llr.sc.gov/pol/medical/PDF/Laws/MPAChapt47.pdf
Physician Assistant	PA	2013 Amended Physician Assistant Practice Act: http://www.llr.sc.gov/POL/Medical/PDF/Laws/2013%20Amended%20Physicians%20Assistant%20Practice%20Act.pdf
Nursing	APRN; RN; LPN	SC Nurse Practice Act: http://www.scstatehouse.gov/code/t40c033.php SC Nurse Regulations: http://www.scstatehouse.gov/coderegs/c091.php
Home Care Services	Skilled Nursing (RN, LPN); Home Care Aide; Personal Care Attendant	SC DHEC Regulation 61-77: http://www.scdhec.gov/administration/regs/docs/61-77.pdf (Home Health) SC DHEC In-Home Care Providers Act: https://www.scdhec.gov/health/licen/ichp-act.pdf (Personal Attendants)
Social Work	LISW-AP; LISW-CP; LMSW; LBSW	SC Board of Social Work Examiners: http://www.llr.state.sc.us/pol/socialworkers/index.asp?file=PUB.HTM
Community Health Worker	CHW	SC DHHS CHW FAQ: https://www.scdhhs.gov/sites/default/files/Community%20Health%20Worker%20FAQ.pdf



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Assistant Secretary for
Preparedness & Response
Washington, D.C. 20201

AUG 13 2012

Jerrie Lynn Kind
Executive Director
National Association of EMS Physicians
P.O. Box 19570
Lenexa, KS 66285

Dear Ms. Kind:

In 2011, over 36 million patients around the nation were treated and transported by Emergency Medical Services (EMS). EMS is an essential part of our health care system and is dedicated to improved health care outcomes through quality improvement. The day-to-day delivery of EMS care is integral to the Office of the Assistant Secretary for Preparedness and Response's (ASPR) commitment to building resilient health care systems and communities around the nation.

A number of participants at the EMS stakeholder meeting in November 2011 noted that some EMS agencies experience difficulty obtaining patient outcome or emergency department (ED) disposition data as part of their quality improvement program. Some hospitals have cited Health Insurance Portability and Accountability Act (HIPAA) privacy requirements when denying requests for patient outcome or ED disposition data. To address this perception and concern, we have developed an information sheet to clarify the circumstances under which the Federal HIPAA Privacy Rule permits a hospital to share patient outcome data with an EMS agency for quality improvement activities.

The enclosed document describes the applicable requirements under the Federal HIPAA Privacy Rule for the disclosure of patient information for quality improvement activities. It does not address applicable requirements for the disclosure of patient information for generalized research purposes. Further, additional consideration should be given to state, local or other (e.g., facility-adopted) privacy standards and rules that may provide restrictions on the sharing of patient information that exceed the Federal HIPAA Privacy Rule standards.

ASPR commends the EMS community's commitment to continuous improvement and supports efforts to enhance resilience and preparedness in communities throughout the nation.

Sincerely,

A handwritten signature in blue ink that reads "Nicole Lurie".

Nicole Lurie, MD, MSPH
Assistant Secretary for Preparedness and Response

Sharing Patient Health Outcome Information between Hospitals and EMS Agencies for Quality Improvement

This information sheet provides clarification as to the circumstances when a hospital and/or emergency department (ED) may share patient outcome information with the Emergency Medical Service (EMS) for quality improvement. The information provided is based on the requirements of the Federal Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule that apply to the disclosure of patient information for quality improvement. It does not address applicable requirements for the disclosure of patient information for generalized research purposes. Further, additional consideration should be given to state, local, or other (e.g., facility-adopted) privacy standards and rules that may provide restrictions on the sharing of patient information that exceed the Federal HIPAA Privacy Rule standards.

If both the hospital and EMS provider are HIPAA covered entities¹, the hospital may share patient health outcome information with the EMS provider for certain health care operations² activities of the EMS provider, such as quality improvement activities, as long as both entities have (or have had in the past) a relationship³ with the patient in question. The hospital may share the information without the patient's authorization, but must make reasonable efforts to disclose only the minimum amount of individually identifiable health information needed for the activity.

Definitions and Examples

¹Covered entity: Includes a health care provider who transmits health information in electronic form in connection with a financial or administrative health care transaction for which the Department of Health and Human Services has developed HIPAA standards. If the EMS provider does not submit electronic claims to a health plan or government payer (such as Medicare or Medicaid) it may not be considered a "covered entity."

Example: EMS and EDs are considered covered entities if they transmit health care claims to a health plan via electronic transactions for payment purposes.

Source: HIPAA Rules at 45 CFR 160.103,
http://edocket.access.gpo.gov/cfr_2007/octqtr/45cfr160.103.htm, and at 45 CFR Part 162,
http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title45/45cfr162_main_02.tpl.

²Health care operations: Encompasses a number of activities to support health care treatment and payment functions, including quality assessment and improvement activities, (including outcomes evaluation and development of clinical guidelines), provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities.

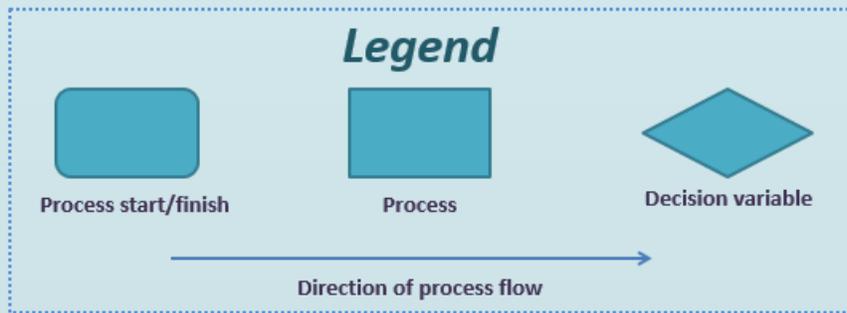
Source: HIPAA Privacy Rule at 45 CFR 164.501
http://edocket.access.gpo.gov/cfr_2007/octqtr/45cfr164.501.htm

³Relationship: Includes a current or prior relationship between a patient and each covered entity.
 Example: EMS rendered treatment to and transported patient X to an ED for health incident Y. The EMS and ED therefore both have a relationship with patient X for health incident Y.

Source: HIPAA Privacy Rule at 45 CFR 164.506(c)(4).

Abbeville Community Paramedicine Program: Crawl Phase Congestive Heart Failure Protocol

Meredith Clemmens
Clemson University
803-292-6049
mclemme@clemson.edu



Abbeville Community Paramedicine Program: Crawl Phase
Congestive Heart Failure Protocol
Goals

Hospital goals:

1. Increase overall quality of life
2. Decrease the patient's number of hospital visits over a 3 month period
3. Improve patient compliance of taking medication
4. Obtain patient satisfaction scores

Patient goals:

1. Maintain satisfactory weight
2. Maintain satisfactory diet plan
3. Maintain a good understanding of their disease process
4. Increase exercise ability
5. Decrease edema
6. Decrease amount of shortness of breath

Abbeville Community Paramedicine Program: Crawl Phase
Congestive Heart Failure Protocol
Policy & Purpose

Policy:

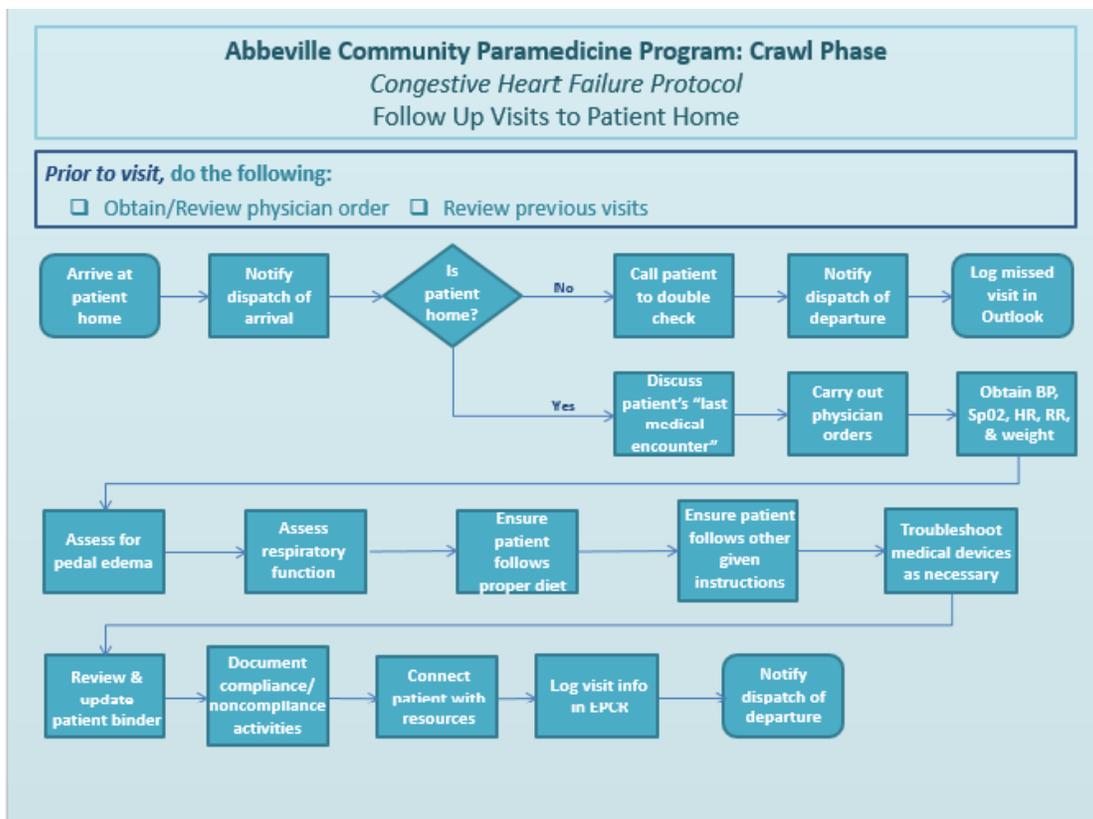
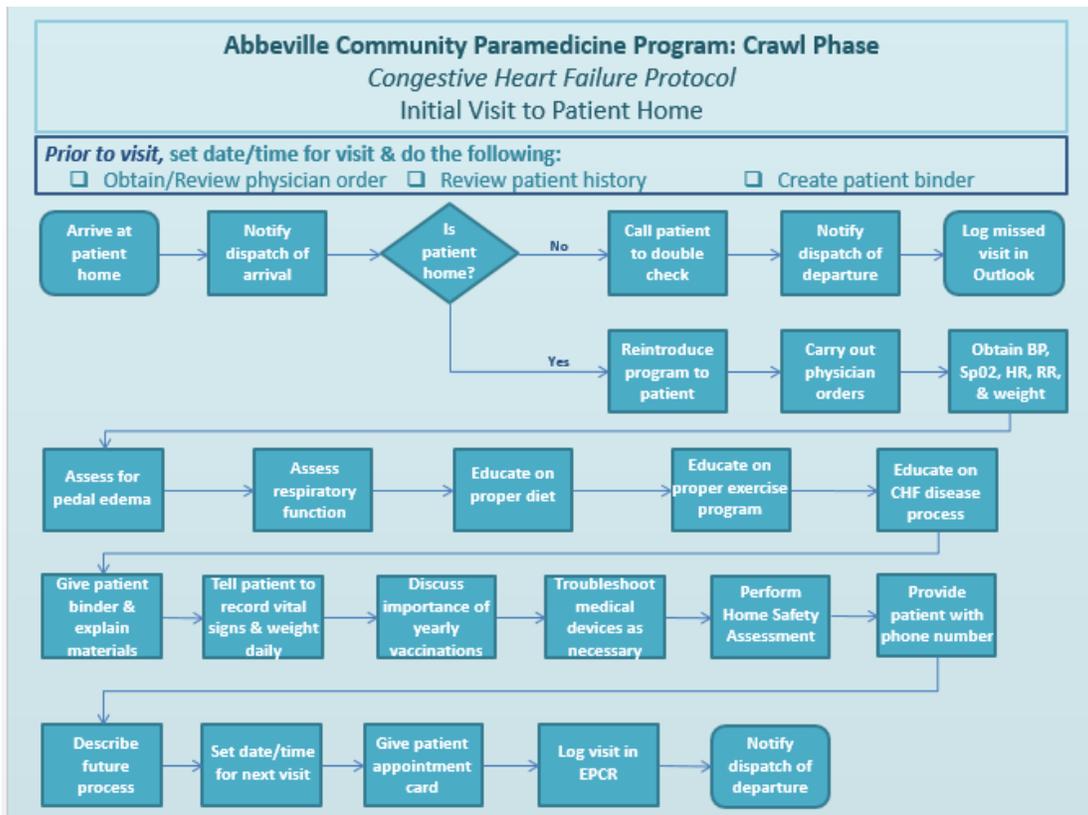
The Community Paramedic will respond to a residence at request from primary physician and follow guidelines outlined by physician's orders for follow up on recently diagnosed or discharged Congestive Heart Failure.

Purpose:

To assist primary physician in observing and documenting recent diagnosed/discharged Congestive Heart Failure patients through written and/or verbal orders to ensure proper compliance with their treatment plan for the purpose of increasing the patient's quality of life and avoid hospital re-admittance.

Abbeville Community Paramedicine Program: Crawl Phase
Congestive Heart Failure Protocol
Expected outcomes

- Patient's overall quality of life improves
- Patient remains compliant with medication
- Patient maintains good understanding of their disease process
- Patient satisfaction improves
- All initial goals are met



Community Paramedic Program

We are here to help!!

The Community Paramedic Program is here to assist you with many of your healthcare needs! Our goal is to help you live healthier, feel better and access the right type of healthcare when you need it most. Best of all, the program is **FREE** of charge!

Our caregivers are certified and experienced Paramedics who will visit you in your home to check on you and make sure your health needs are being met. When we arrive, we will work together with you and a physician to create action steps to ensure you are getting the best care possible.

The Community Paramedics can do things like provide home safety assessments, check your blood pressure, assist you with your medications, answer questions, check on you after you have been in the hospital as well as provide many other services to improve your health and quality of life. We can also help find community resources to assist you with other needs you may have.

All of us in the Community Paramedic Program look forward to working with you. Please feel free to contact us should you have any questions.

Our Team...



Brandon Johnson, NREMT-P

Brandon has been a Paramedic since 2008 and is a shift supervisor. He has thirteen years of EMS experience, starting as a Junior member. Brandon has been in Abbeville since 2006 and is certified in Basic Life Support and Advanced Cardiac Life Support.



Eric Livingston, NREMT-P

Eric has twelve years of EMS experience, seven as a Paramedic. He has been with Abbeville County EMS for seven years. Eric is an Assistant Supervisor and is certified in Basic Life Support and Advanced Cardiac Life Support.



David Payton, NREMT-P

David is Abbeville County EMS Assistant Supervisor and has 23 years of firefighter and Paramedic experience. He is certified in Basic Life Support and Advanced Cardiac Life Support.



Will Blackwell, NREMT-P

Will is the Deputy Director of Emergency Services. He has been involved with EMS and fire services for twelve years and has been a Paramedic since 2007. Will is certified in Basic Life Support and Advanced Cardiac Life Support.



****If you have an emergency, please dial 911****

The Community Paramedic Program is provided by Abbeville County EMS in partnership with Abbeville Area Medical Center

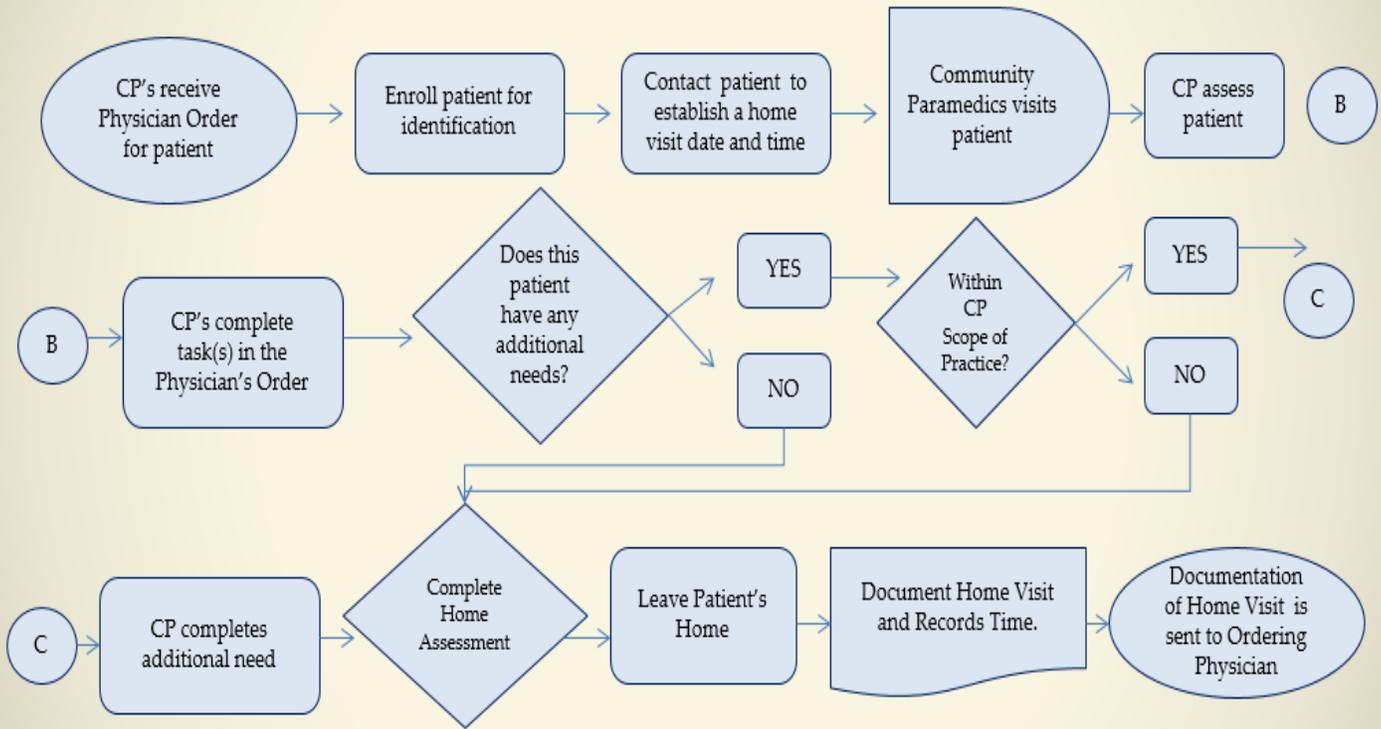
Community Paramedic Program Contact Information

Office: 366-2400 x2230 • Cell: 378-0571 • Dispatch: 366-8451 • Email: cp@abbevillecountysc.com

Abbeville's CP Truck Mark-Up

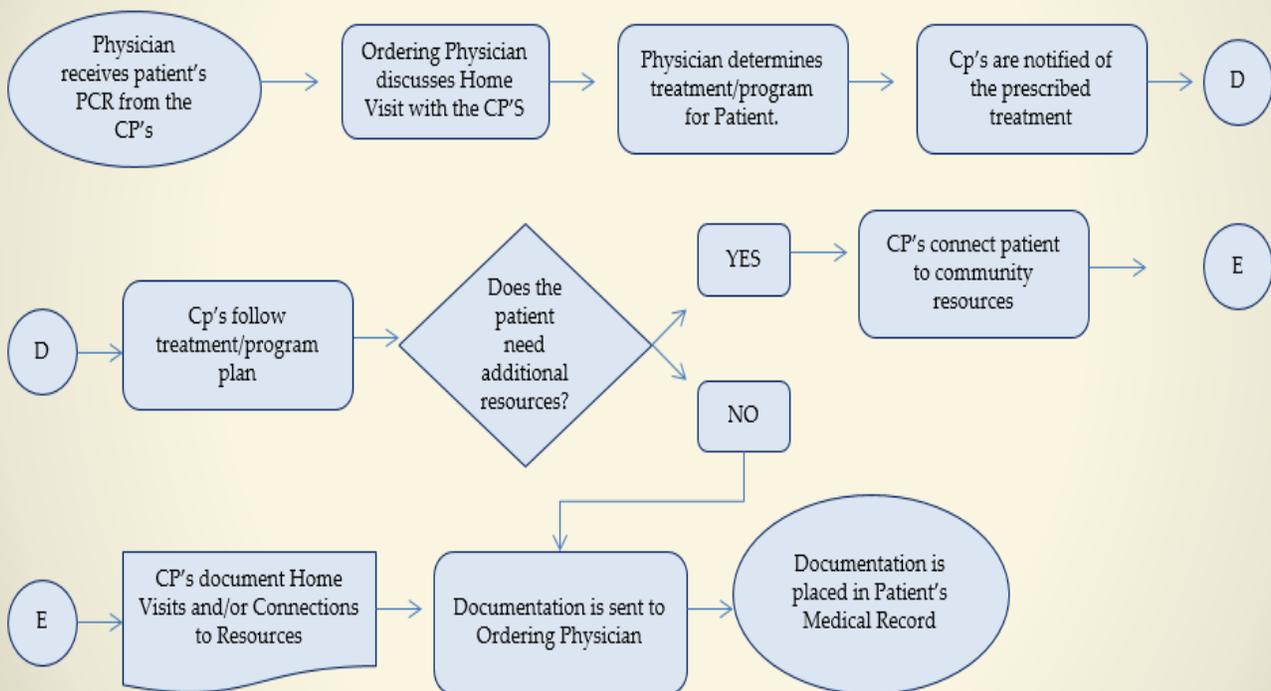


CP Home Visit



"Dedicated to providing access to quality health care in rural communities"

Follow Up



"Dedicated to providing access to quality health care in rural communities"



Unique Patient ID: _____

Date: _____

Conducting Home Visit: _____

Initial Home Visit Checklist

	YES	NO	N/A		
1a) Did you complete the Home Health Eligibility Assessment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	YES	NO	N/A		
1b) Is the CP patient eligible for Home Health Services? If N/A, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	CHF	DM	HTN	COPD	Falls
2a) What is the CP Patient's Diagnosis? (Check all that apply)	<input type="checkbox"/>				
	YES	NO	N/A		
2b) Does the CP Patient have comorbidities? If N/A, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	CHF	DM	HTN	COPD	Falls
3a) What Diagnosis Protocol has Dr. Scott placed the CP Patient in? (Check all that apply)	<input type="checkbox"/>				
	YES	NO	N/A		
3b) Have you explained the Physician Prescribed Protocol and how the protocol relates to their Plan of Treatment ? If N/A, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	YES	NO	N/A		
4) Have you explained and given the Patient Binder to the CP Patient? If N/A, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	YES	NO	N/A		
5a) Have you collected an Active Rx Medication List from the CP patient? If N/A, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	YES	NO	N/A		
5b) Have you discussed Medication Compliance with the CP patient? If N/A, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	YES	NO	N/A		
5c) Have you completed Medication Reconciliation to establish the most complete and accurate medication list for enrolled CP patients. If N/A, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	YES	NO	N/A		
6) Have you completed the Home Safety Assessment: If N/A, please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

DRAFT

Abbeville's Patient Canceled Appointment Tool

Patient canceled appointment/not home

Patient name:

Address:

Original appointment time and date:

Did the patient call in advance to cancel?

Did the patient reschedule for a later appointment?

Appendix I Program Evaluation

Link:

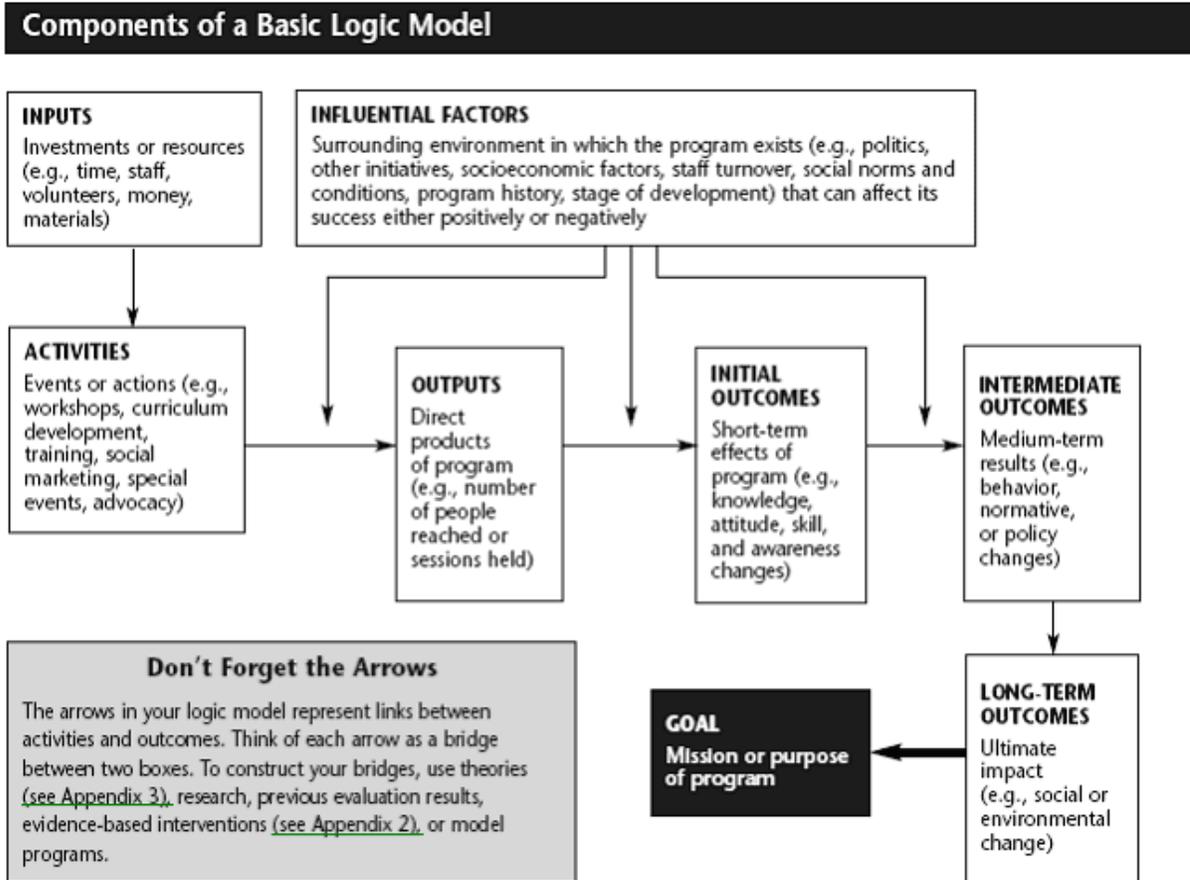
1) Community Paramedicine Evaluation Tool:

<http://www.hrsa.gov/ruralhealth/pdf/paramedicevaltool.pdf>

Resources:

2) [Draft Logic Model Example](#)

Logic Model Example



Centers for Disease Control and Prevention. *Healthier Worksite Initiative Logic Model*. Accessed on March 5, 2014. http://www.cdc.gov/nccdphp/dnpao/hwi/programdesign/logic_model.htm

March 11th, 2014