

Promote Use of Community Paramedicine

Cost Driver Targeted: Inpatient/emergency department utilization

OVERVIEW

Decreasing unnecessary emergency department (ED) visits has been an important health policy goal as a result of the high cost of emergency services and how they contribute to unnecessary inpatient utilization. To achieve this goal, some state policymakers are rethinking how emergency medical services (EMS) providers could expand their role to deliver the “right care, in the right place, at the right time.” In most traditional EMS models, the primary responsibility of EMS providers is to stabilize patients in crisis and then transport them to EDs for treatment. Community paramedicine, a component of mobile integrated health, is an emerging model in which EMS providers deliver health services without transporting individuals to EDs. In this model, EMS providers work in partnership with public health and health care systems to deliver care. They might assess a patient’s condition, deliver treatments in the home or in the field, or conduct screenings and other services.

Taos, New Mexico, implemented one of the first community paramedicine programs in the United States in the 1990s. Since then, community paramedicine has been increasing in popularity nationally and internationally. As of 2018, more than 200 [community paramedicine programs](#) were operating in the United States, with many of them located in rural areas.

Community paramedicine programs have been found to decrease health care spending by preventing use of more costly and unnecessary services, such as inpatient or ED care, while achieving high satisfaction ratings from patients. In recent years, many states have started to explore and implement approaches to support more widespread use of community paramedicine as part of mobile integrated health solutions.



KEY STEPS IN DESIGN AND IMPLEMENTATION

Identify and resolve statutory barriers to community paramedicine. Some states restrict the role of EMS providers in a way that prevents them from delivering community paramedicine services. Other states, including [Minnesota](#) and [Wisconsin](#), have enacted legislation that broadly defines and enables community paramedicine services. Maine amended its statute in 2012 to allow the state EMS board to establish [12 pilot community paramedicine programs](#) before making community paramedicine programs [permanent in 2017](#). In California, the Health Workforce Pilot Project Program temporarily waived sections of the health and safety code to allow community paramedicine pilots.

States can review their existing laws and regulations to see whether they restrict or prohibit community paramedicine. If so, they can decide whether to pursue a broad “fix” or a narrower exemption (e.g., to allow for a pilot program).

In addressing statutory barriers to community paramedicine, key steps for states include reviewing where oversight of these programs should reside (e.g., within a licensing authority) and considering whether they should delineate a scope of practice or allow for delegated practice under a physician’s medical license.¹

Determine areas of focus. Community paramedicine can be applied in a number of different ways. For example, states might choose to focus on postdischarge care or newborn assessments. Some programs have focused on specific chronic conditions, whereas others may address alternative transport sites (e.g., primary care, urgent care, or detoxification centers). Training and supervision, including requirements for who serves as medical control for the community paramedicine program, should be tailored to the area of focus. A needs assessment can identify significant gaps in existing health care services, which populations most frequently use EMS, the most frequent conditions requiring hospital readmission, and the greatest health care needs, from the perspective of providers, patients, and other stakeholders. This can help prioritize focus areas and support the most strategic use of resources.

Determine how community paramedicine services will be reimbursed. In many cases, payers reimburse EMS providers only when the patient is transported to the ED. The lack of reimbursement for care other than transport has been a major barrier to sustaining community paramedicine initiatives, but in recent years, support for reimbursing community paramedicine services has increased. Medicare recently launched the Emergency Triage, Treat, and Transport (ET3) model, which gives more flexibility to ambulance care teams to address the emergency health care needs of Medicare fee-for-service beneficiaries following a 9-1-1 call. At the state level, there has been significant progress in increasing opportunities for reimbursement, with commercial and Medicaid reimbursement [now occurring in a number of states](#).

Options for state policymakers to support community paramedicine services include:

- *Pilot or grant funding:* However, this approach has the obvious drawback of not providing for a sustainable, ongoing funding stream.
- *Medicaid reimbursement:* A number of state Medicaid agencies (notably in Arizona, Georgia, Minnesota, Nevada, and Wyoming) reimburse for community paramedicine services, and 14 states provide some reimbursement for EMS treatment without transport. Medicaid reimbursement can be an important first step that facilitates future commercial reimbursement, such as by establishing fee schedules and billing codes.
- *Commercial reimbursement:* After Medicare, commercial carriers are the [second-largest payer](#) by volume for EMS transports. Many commercial insurers have launched community paramedicine programs. For example, Blue Cross Blue Shield of New Mexico has [a program with Albuquerque’s ambulance services](#) to visit members within 72 hours following an ED visit or hospital discharge. In 17 states, commercial insurers reimburse for community paramedicine programs. States could grow commercial carrier reimbursement by addressing regulatory barriers; leading by example by advancing reimbursement in public programs and initiatives; facilitating multipayer alignment; and requiring plans regulated by the state to include community paramedicine services (although we are not aware of states that have done so).

¹ For example, Minnesota’s Community Paramedic Toolkit details issues related to certification and scope of practice. See Minnesota Department of Health, [Community Paramedic Toolkit](#) (MDH, Dec. 2016).

- *Provider partnerships:* As providers are increasingly paid through financial models that make them accountable for patients' outcomes, they may be more interested in forming partnerships with community paramedicine programs to extend their reach to care for patients in the home. Colorado's Eagle County Ambulance District has had a [shared savings arrangement](#) with an area hospital to recoup a portion of the savings that results from preventing readmissions. Some hospitals operate their own EMS, which can facilitate coordination between health care providers and the EMS system. In addition to health systems, hospice and home health providers also can be important potential partners. States could support provider partnerships with community paramedicine by facilitating connections between health care and EMS providers, and by easing regulatory barriers.

EVIDENCE OF IMPACT

Community paramedicine programs have been found to decrease ED and inpatient utilization in multiple studies, while achieving [high patient satisfaction and improved health outcomes](#). Studies of several programs — including ones focused on a [Medicare Advantage population](#), a [small rural community](#), and a [large city](#) (Houston) — suggest that community paramedicine may have a positive return on investment. [Case studies](#), such as the [MedStar Mobile Health Program](#) in Texas, for example, have demonstrated savings from avoiding ED and inpatient admissions.

Although these studies have not specifically focused on commercially insured populations, a number of studies involved geographically defined populations that presumably included commercially insured individuals. [REMSA in Nevada](#) has reported savings in different populations, including the commercially insured.

Researchers have estimated the total potential savings from community paramedicine at [\\$283 million to \\$560 million for Medicare each year](#); this could double if private payers instituted similar policies.

IS THIS STRATEGY A GOOD CHOICE FOR YOUR STATE?

This approach is likely to have broad appeal across states with different political environments. It may be of particular interest to states that:

- are interested in improving access to care in rural areas
- have EMS providers who are interested in developing community paramedicine initiatives
- have a payer or provider who could serve as a partner in moving this initiative forward.

Some community paramedicine programs have encountered opposition because of concerns about the scope of practice of community paramedicine providers vis-à-vis nurses and other health professionals. Engaging with community members and stakeholders throughout the process can help clarify roles and address concerns.

EQUITY CONSIDERATIONS

Community paramedicine holds particular promise for improving access and outcomes for individuals with high needs as well as for those in rural or underserved areas. It will be important to support research to better understand patient satisfaction and health outcomes by race/ethnicity, as well as to monitor for adverse effects.

OTHER POTENTIAL UNINTENDED CONSEQUENCES OR LIMITATIONS

Under these types of programs, community paramedicine providers will need training appropriate to the services they will be providing. Some states stipulate training requirements, and some require formal recognition after training, such as licensure, certification, approval, or endorsement. States should be prepared to define and oversee such requirements.

As with initiatives that introduce alternative settings of care (e.g., urgent care and retail clinics, for example), monitoring is important to ensure that community paramedicine service volume does not grow so much as to increase overall utilization and erase the potential for cost avoidance. Similarly, it is important to avoid duplication of services. From a practical standpoint, ensuring that community paramedicine providers are communicating effectively (e.g., through a shared electronic health record) with a patient's regular provider is important to prevent fragmentation of care.

States should also monitor patient outcomes carefully to ensure that patients are receiving appropriate care and being appropriately triaged to EDs when warranted.

RESOURCES

Janet Coffman and Connie Kwong, *Left Behind in California: Comparing Community Paramedicine Policies Across States* (California Health Care Foundation, Nov. 2019).

"Rural Community Paramedicine Toolkit," Rural Health Information Hub, 2020.

National Association of Emergency Medical Technicians, *Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey* (NAEMT, 2018).