Submitted by The Nebraska Emergency Medical Services Association, Children’s Hospital & Medical Center, Nebraska State Volunteer Firefighters Association, Nebraska Flight Association, Medics At Home, the Board of Emergency Medical Services, and the Office of Emergency Health Systems
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>3</td>
</tr>
<tr>
<td>Description of the Applicant Group</td>
<td>4</td>
</tr>
<tr>
<td>Other groups, Associations, or Organizations in Nebraska</td>
<td>5</td>
</tr>
<tr>
<td>Current Status of Credentials</td>
<td>8</td>
</tr>
<tr>
<td>Occupational Functions</td>
<td>10</td>
</tr>
<tr>
<td>Practitioner Supervision</td>
<td>11</td>
</tr>
<tr>
<td>Educational and Training Requirements</td>
<td>12</td>
</tr>
<tr>
<td>Occupational Work Settings</td>
<td>12</td>
</tr>
<tr>
<td>Continuing Education and Competency Evaluation</td>
<td>13</td>
</tr>
<tr>
<td>Regulations in Other States</td>
<td>14</td>
</tr>
<tr>
<td>Additional Questions about this Proposal</td>
<td>14</td>
</tr>
<tr>
<td>Appendix</td>
<td>18</td>
</tr>
<tr>
<td>Appendix A: Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey</td>
<td>18</td>
</tr>
<tr>
<td>Appendix B: National EMS Scope of Practice Model – National Highway Traffic Safety Administration</td>
<td>19</td>
</tr>
<tr>
<td>Appendix C: National Association for Emergency Medical Professionals MIH-CP Roundup</td>
<td>20</td>
</tr>
<tr>
<td>Appendix D: Veteran paramedic pairs community paramedic, mental health specialist in new response model</td>
<td>25</td>
</tr>
<tr>
<td>Appendix E: Pilot Program Support Letters</td>
<td>30</td>
</tr>
</tbody>
</table>
Introduction

Healthcare in Nebraska continues to be a changing and complex environment. Nebraska continues to see shortages in all levels of healthcare personnel, including: clinicians, support staff, and other related services. It is paramount to ensure the best possible care for our patients and EMS providers our often an unused resource in non-emergent community healthcare initiatives. Mobile Integrated Healthcare-Community Paramedicine (MIH-CP) programs have shown to help improve patient care outcomes, reduce emergency department recidivism, and decrease healthcare system costs. MIH-CP provides an opportunity to close gaps in healthcare and provide a collaborative, interdisciplinary approach to assessing, monitoring and caring for patients. All healthcare providers in Nebraska need to work together to deliver the best level of care all Nebraska residents deserve. The applicant group submits the following proposal, based on considerable evidence demonstrating the many benefits of implementing MIH-CP programs, based upon individual community needs assessments. Thank you for your consideration of this credentialing review application.
Description of the Applicant Group

1. Provide the following information for the Applicant group(s):
   a. Name, address, telephone number, e-mail address, and website of the applicant group in Nebraska, and any national parent organization;

   **Applicants:**
   - Nebraska Office of Emergency Health Systems
     - Contact: Tim Wilson, Program Manager
     - Telephone: 402.471.0124
     - Email: Tim.Wilson@nebraska.gov
     - Website: DHHS.ne.gov/ems
   - Nebraska Board of Emergency Medical Services
     - Contact: Michael Miller, EMS Board Member
     - Telephone: 402.280.1280
     - Email: MikeMiller@creighton.edu
   - Nebraska Emergency Medical Services Association
     - Contact: Debbie Von Seggern, Immediate Past President
     - Telephone: 402.719.0105
     - Email: president@nemsa.org
     - Website: www.nemsa.org
   - Nebraska State Volunteer Firefighters Association
     - Contact: Marlene Bomar, President
     - Telephone: 402.761.2211
     - Email: mbomar@telebeep.com
     - Website: www.nsvfa.org
   - Nebraska Association of Air Medical Services
     - Contact: Dan Duncan
     - Telephone: 402.610.1271
     - Email: dan.duncan@airmethods.com
     - Website: www.neaams.org
   - Children’s Hospital and Medical Center
     - Contact: Megan Sorensen
     - Telephone: 402.955.5146
     - Email: mesorensen@childrensomaha.org
     - Website: www.childrensomaha.org/transport
b. Composition of the group and approximate number of members in Nebraska

Emergency Medical Services throughout Nebraska are provided by both paid and volunteer EMS agencies. As of February 2018 there are a total of 421 licensed ambulance services in Nebraska; 319 Basic Life Support (BLS), and 102 Advanced Life Support (ALS). EMS Education programs are also approved to provide EMS education in Nebraska by the Department of Health and Human Services, adhering to National EMS Education Standards and Guidelines. Currently there are 20 approved EMS training programs in Nebraska. At the present time there are five different levels of EMS personnel licensure in Nebraska, including: 415 Emergency Medical Responders, 4,920 Emergency Medical Technicians, 24 Advanced EMTs, 62 Emergency Medical Technician-Intermediates, and 1,504 Paramedics.

c. Relationship of the group to the occupation dealt with in the application

The applicant group has been assembled to represent each major stakeholder interest throughout Nebraska. The request to engage in the Nebraska Credentialing Review Program occurred as a result of proposed legislation in the EMS Act before the Nebraska 105th Legislature, 2nd Session. Specific content relating to the removal of “out-of-hospital” and the ability for EMS Providers, Emergency Medical Technician and above, to work in more than just Hospitals and Healthcare Clinics was removed from the bill following opposition from the nursing community, citing the proposal constituted an expansion of EMS scope of practice. Community Paramedicine was removed from the proposed legislation because of the same opposition. Stakeholders agreed that a 407 Credentialing Review would be pursued to address if the removal of “out-of-hospital” changes EMS scope of practice; to allow EMS personnel to work in all health care settings, not just on ambulances; and to allow for the practice of Mobile Integrated Healthcare - Community Paramedicine. Tim Wilson represents the Nebraska Office of Emergency Health Systems; Michael Miller represents the Nebraska Board of EMS; Debbie Von Seggern represents the Nebraska EMS Association; Marlene Bomar represents the Nebraska State Volunteer Firefighters Association; Dan Duncan represents the Nebraska Association of Air Medical Services; Megan Sorensen represents Children’s Hospital and Medical Center, a provider of critical care transportation; and Tom Townsend represents Medics at Home, a private EMS agency.

Other groups, Associations, or Organizations in Nebraska

2. Identify by title, address, telephone number, email address, and website of any other groups, associations, or organizations in Nebraska whose membership consists of any of the following:
   a. Members of the same occupation or profession as that of the applicant group;
      The applicant group represents stakeholders involved in the delivery and oversight of emergency medical services. In particular, the Nebraska Board of EMS has membership that
includes emergency physicians and nursing. Most licensed EMS personnel in Nebraska are members of either the Nebraska EMS Association or the Nebraska State Volunteer Firefighters Association.

b. **Members of the occupation dealt with in the application;**
The occupation dealt with in the application is the same as that represented by the applicant group.

c. **Employers of the occupation dealt with in the application;**
EMS personnel work in a variety of settings and may work or volunteer for county government, municipal government, private not-for-profit ambulance services, private for-profit ambulance services, aeromedical transport agencies, hospitals, clinics, academic and industrial settings.

d. **Practitioners of the occupations similar to or working closely with members of the occupation dealt with in the application;**
There is a wide variety of practitioners and occupations working closely with EMS personnel including physicians, advanced practice nurses, nurses, physician assistants, fire department personnel (that may not hold an EMS license), and law enforcement officials.

---

Nebraska Medical Association  
233 South 13th Street, Suite 1200  
Lincoln, NE  68508-2091  
402.474.4472  
[www.nebmed.org](http://www.nebmed.org)

Nebraska Chapter - American College of Emergency Physicians  
C/O National ACEP  
4950 West Royal Lane  
Irving, TX  75063-2524  
800.798.1822, Ext. 3312  
[www.neacep.org](http://www.neacep.org)

Nebraska Hospital Association  
325 Salt Creek Circle, Suite 100  
Lincoln, NE  68504-4778  
402.742.8140  
[www.nebraskahospitals.org](http://www.nebraskahospitals.org)

Nebraska Academy of Physician Assistants  
1111 Lincoln Mall, Suite 308  
Lincoln, NE  68508  
402.476.1528  
[www.nebraskapa.org](http://www.nebraskapa.org)
e. **Educators or trainers of prospective members of the occupation dealt with in the application;**

After identifying the need for Community Paramedicine through a local needs assessment, community paramedicine education may be handled in a variety of different ways. Training of EMS personnel may be provided by physicians, nurses, nurse practitioners, physician assistants, mental health workers, social workers, public health officials, addiction specialists, and others on the specific services that will be provided. In addition, courses for Community Paramedicine education are accessible to providers nationally.
f. Citizens familiar with or utilizing the services of the occupation dealt with in the application (e.g., advocacy groups, patient rights groups, volunteer agencies for particular diseases or conditions, etc.); and

Outside the medical and emergency services communities, it is not known what citizen groups may have an interest in this application. Currently Community Paramedicine is not recognized or regulated in Nebraska.

g. Any other group that would have an interest in the application.
None we are aware of at this time.

Current Status of Credentials

3. If the profession is currently credentialed in Nebraska, provide the current scope of practice of this occupation as set forth in state statutes. If a change in this scope of practice is being requested, identify that change. This description of the desired scope of practice constitutes the proposal. The application comprises the documentation and other materials that are provided in support of the proposal.

There is no current credential for a Community Paramedicine programs or personnel in Nebraska.

4. If the profession is not currently credentialed in Nebraska, describe the proposed credential and the proposed scope of practice, and/or the proposed functions and procedures of the group to be reviewed. This description of the desired scope of practice and the proposed credential constitute the core of the proposal. Also, please describe how the proposal would be administered. The application comprises the documentation and other materials that are provided in support of the proposal.

Mobile Integrated Health – Community Paramedicine (MIH-CP) programs have been on the rise for the past decade. According to the Mobile Integrated Healthcare and Community Paramedicine (MIH-CP): 2nd National Survey (Appendix A), forward thinking EMS agencies designed the programs to meet individual community healthcare needs following the Institute for Healthcare Improvement’s Triple Aim of improved patient experience of care, improved population health and reduced per capita cost of healthcare. This is accomplished by identifying gaps in healthcare specific to a community. Programs are not meant to compete with existing services being provided. MIH-CP services that may be provided include but are not limited to:

- Providing help to patients with chronic disease management and education, including post-hospital discharge follow-up to prevent admissions or re-admissions;
- Navigate patients to alternate destinations such as primary care, urgent care, mental health or substance abuse treatment centers rather than the emergency room;
- Provide telephone triage, advice or other assistance to non-urgent 911 callers rather than sending scarce resources such as an ambulance; and
- Use telemedicine technology facilitating patient in home interaction with healthcare providers at another location.
This proposal seeks to establish Community Paramedicine within the State of Nebraska. This will require changes to terminology currently used to describe EMS within Nebraska Statute and Rules and Regulations. First is the removal of the reference “out-of-hospital.” “Out-of-hospital” is a location of service and should not be interpreted as part of the scope of practice as it is now in statutes and regulation. The National EMS Scope of Practice Model (Appendix B) states EMS professionals are increasingly practicing in areas other than “out of hospital,” typically referencing ambulances. For more than two decades and currently, Nebraska EMS personnel practice in out of hospital, in hospital and other health clinic settings demonstrating that “out of hospital” is no longer a relevant term.

Community Paramedicine providers and personnel work in locations other than hospitals or health care clinics. The providers will be providing non-emergent care to patients within their homes and other locations. Currently the Emergency Medical Services Practice Act restricts EMS providers to “include the identification of and intervention in actual or potential health problems of individuals and are directed toward addressing such problems based on actual or perceived traumatic or medical circumstances prior to or during transportation to a hospital or for routine transportation between health care facilities or services.” The EMS Act further restricts EMS Services to the “perceived individual need for medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury.” Healthcare continues to evolve rapidly, and more and more care is transitioning to the in-home environment, or settings outside of hospitals. Community Paramedicine and EMS providers may work in a variety of health care settings and provide care in homes for non-emergent situations. The necessary changes to the EMS Practice Act will allow EMS Services and personnel (license level of EMT, AEMT, EMT-I or Paramedic) to work in a variety of health care settings (i.e. nursing home, hospital, etc.) and to provide care in non-emergent situations, is essential for the benefit of patients and the healthcare system.

EMS services will be required to obtain approval from the Nebraska EMS Board and Nebraska Department of Health and Human Services (DHHS) prior to any EMS Service or provider beginning MIH-CP services. The EMS Service shall submit to the EMS Board and DHHS an application that will consist of the community healthcare needs assessments. A rural health assessment performed by local hospitals or public health districts may be utilized to satisfy the community needs assessment. Additionally, the application will need to outline the details of what services will be provided, including copies of any protocols that may be needed, policies that are created, how EMS personnel and other healthcare professionals will receive and maintain the education on patient care for the services provided, and how medical oversight of the program will be provided by the physician medical director. The physician medical director will need to sign and approve all aspects of the application. Applications will be submitted, reviewed and inspected by subject matter experts before launching an MIH-CP program, and upon EMS services regularly scheduled inspection. The EMS Practice Act and Rules and Regulations must be changed to allow EMS services to provide these MIH-CP without having to obtain a Home Health Agency License. EMS services will be required to document all patient encounters with the minimum standards required by 172 NAC 12.004.09C and all subsections. The regulation should be updated to require the Nebraska Emergency Medical Services Data Software System to provide for a Community Paramedicine component.
Occupational Functions

5. Describe in detail the functions typically performed by practitioners of this occupation, and identify what if any specific statutory limitations have been placed on these functions. If possible, explain why the Legislature created these restrictions.

Community Paramedicine (CP) programs are not currently recognized in statutes or regulations. CP programs with formal associations with hospitals have been piloted in Nebraska. Because CP is not recognized, no services have been officially recognized.

No statutory limitations exist because the practice is not recognized in statutes. Not advancing the Community Paramedicine proposal may result in continued gaps in healthcare, potential return visits to the emergency room and/or admissions or readmissions to hospitals, resulting in less effective care and increased costs for the patient and the entire healthcare system.

6. Identify other occupations that perform some of the same functions or similar functions.

Home Health care, the Visiting Nurses Association (VNA), social service agencies, and other hospital and clinic based agencies provide similar services in Nebraska. Community Paramedicine programs target gaps in service that these agencies are not able to fill based on community needs in a collaborative fashion. These programs help coordinate care among the entire continuum of healthcare services. MIH-CP programs provide a service to help keep patients home, connect them with appropriate services, reduce re-admission rates, increase continuity of care, and improve patient care. It has been shown that MIH-CP programs help to aid in the reduction of high volume users of the 911 system and ER admissions. Community Paramedicine requires physician medical oversight.

7. What functions are unique to this occupation? What distinguishes this occupation from those identified in question 6?

The functions that are most unique to a Community Paramedicine program are:

- Providing help to patients with chronic disease management and education, including post-hospital discharge follow-up to prevent admissions or re-admissions;
- Navigate patients to alternate destinations such as primary care, urgent care, mental health or substance abuse treatment centers rather than the emergency room;
- Provide telephone triage, advice or other assistance to non-urgent 911 callers rather than sending scarce resources such as an ambulance; and
- Use telemedicine technology facilitating patient in home interaction with other healthcare providers at another location.

These programs exist based on community needs assessments with the purpose of filling the gaps in healthcare services that are not being provided or in collaboration with existing programs.

One Nebraska pilot program provides post-discharge visits that are short term, one to two visits, for the first several days after a hospital stay to determine if discharge instructions are being followed and to assess the patient’s and family’s transition to home-based care. The visits ensure the patient is doing well, their home is safe, and they are experiencing no issues that requires medical treatment. The pilot programs have patients who initially refuse or do not qualify for home health services that
have become receptive after Community Paramedicine intervention. Furthermore, existing services are insufficient to meet these needs in most communities.

**Practitioner Supervision**

8. Identify other occupations whose members regularly supervise members of this occupation, as well as other occupations whose members are regularly supervised by this occupation. Describe the nature of the supervision that occurs in each of these practice situations.

EMS Agencies pursuing Mobile Integrated Health - Community Paramedicine (CP) services need the authorization of their Physician Medical Director. Furthermore, agencies providing these programs shall be required to seek approval from the Nebraska Board of EMS and DHHS. CP programs will also follow EMS Rules and Regulations regarding the collection of data for patients to the DHHS provided Patient Care Record tracking system.

According to the National Association of Emergency Medical Services Physicians (NAEMSP) Community Paramedicine Roundtable (Appendix C), there can be three approaches to supervision. The first is a traditional Physician Medical Director where personnel operate under protocols, standing orders and online medical direction. The second approach is where Community Paramedicine providers are joined by other professions, such as a primary care physician, receiving guidance from non-EMS physicians. The final approach is an Advanced Practice Provider model where Community Paramedicine providers consult with medical direction but can practice mostly independently.

9. What actions, judgements, and procedures of this occupation can typically be carried out without supervision or orders? To what extent is this occupation, or portions of its practice, autonomous?

As noted in item 8 above, MIH-CP programs are under the supervision of a physician who has medical control oversight. The nature of these programs allows providers to practice autonomously during patient interaction, utilizing protocols, online medical direction, or standard operating procedures. For Community Paramedic programs, clinicians operate with collaborative and accessible medical oversight, recognizing the need for autonomous decision-making based on the needs of the patient. Patients are assessed, diagnostics obtained and analyzed, and plans of care implemented with a set of protocol-driven guidelines. Community Paramedicine programs work with the patients Primary Care Provider, clinic, other agencies or discharge supervisor.

10. Approximately how many people are performing the functions of this occupation in Nebraska, or are presenting themselves as members of this occupation? To what extent are these people credentialed in Nebraska?

Currently there is no credentialing process for Community Paramedicine programs within Nebraska. Nebraska does have EMS agencies that are engaged in pilot Community Paramedicine programs. The programs are affiliated with a hospital for program direction and oversight. Additional training may be required by the program or physician medical director in order to fulfill the objectives of the program. These programs utilize currently credentialed EMS personnel.
Educational and Training Requirements

11. Describe the general level of education and training possessed by practitioners of this occupation, including any supervised internship or fieldwork required for credentialing. Typically, how is this education and training acquired?

There is no degree requirement in the United States for EMS personnel at any level. EMS providers are generally educated utilizing National Educational Standards and Guidelines. Upon successful program completion candidates are eligible for the National Registry of EMTs certification examination, the exam utilized for Nebraska licensure. EMS providers complete supervised hospital and ambulance internship with demonstrated competencies as established by the educational program.

Community Paramedic providers may be educated by Physician Medical Directors (PMD) or other qualified healthcare providers. The educational training that will be required will be determined by the healthcare gaps they will be supporting. PMDs will determine the education that will be needed for the providers within the EMS Service, and the educational requirements will be included in the application the EMS Service will make to the EMS Board and DHHS for approval.

Comprehensive Community Paramedicine training programs are offered nationally and the International Board of Specialty Certification does offer certification based on examination.

Occupational Work Settings

12. Identify the work settings typical of this occupation (e.g., hospitals, private physicians' offices, clinics, etc.) and identify the predominant practice situations of practitioners, including typical employers for practitioners not self-employed (e.g., private physician, dentist, optometrist, etc.).

Community Paramedicine services are provided in a variety of clinical and non-clinical settings.

Predominantly, services are utilized as members of collaborative teams responsible that ensure the best possible care for and outcome of the the patient, often in the patient's own home.

13. Do practitioners routinely serve members of the general population? Are services frequently restricted to certain segments of the population (e.g., senior citizens, pregnant women, etc.)? If so, please specify the type of population served.

Providers of Community Paramedicine services, as members of complex interdisciplinary healthcare teams, engage in the care of patients of all ages with a variety of medical conditions. Patients may span all populations based on the specific gaps in healthcare identified within a community. Pilot programs in Nebraska demonstrate positive results helping post-discharge patients suffering from new or existing conditions such as congestive heart failure, chronic obstructive pulmonary disease, pneumonia and peripheral neuropathy.

14. Identify the typical reasons a person would have for using the services of a practitioner. Are there specific illnesses, conditions or situations that would be likely to require the services of a practitioner? If so, please specify.

Nebraska, as with many rural states, is seeing a decrease in the availability of healthcare providers and services and an increase in the gaps in healthcare. Patients can be discharged from a hospital stay without any follow-up services leading to frequent ER visits and re-admissions. Medicare already
penalizes reimbursements for diseases like congestive heart failure, chronic obstructive pulmonary disease, pneumonia and peripheral neuropathy. CP services will help patients transition back to home living by ensuring a safe home and reduce re-admissions. This is one example of the type of services that could be provided. Many other types of services exist for Community Paramedicine programs to enhance patient care and fill the gaps in healthcare services. Each program will be unique to the needs of its community.

15. Identify the typical referral patterns to and from members of this occupational group. What are the most common reasons for referral?

Referrals for CP programs come from a variety of different sources such as emergency rooms, physicians, clinics, and hospitals. Existing Nebraska pilot programs have EMS agencies working closely with hospitals, clinics, and Managed Care Organizations to provide these services. These programs offer patients visits, currently free of charge to the patient, as a part of standard discharge processes. Nebraska pilot Community Paramedicine visits have resulted in referrals to other long-term care agencies where patients did not initially qualify for, or want home services.

Nationally, Community Paramedicine programs have an established system to refer patients to services or health facilities rather than the emergency room. One program pairs a community paramedic with a mental health specialist to assist patients with a mental health diagnosis. This program connects patients to services and mental health providers as described in Veteran paramedic pairs community paramedic, mental health specialist in new response model (Appendix D).

16. Is a prescription or order from a practitioner of another health occupation necessary in order for services to be provided?

A prescription is not required. EMS agencies and providers are under the supervision of their Physician Medical Director to provide Community Paramedic services. The ongoing care of patients during visits is guided by the written protocols developed and approved by the EMS agency’s physician medical director, and subsequent approval by the DHHS and Nebraska Board of EMS. Online medical direction can be obtained from the physician medical director, primary care provider, hospital, or clinic.

Continuing Education and Competency Evaluation

17. How is continuing competence of credentialed practitioners evaluated?

Continued competency of personnel involved with providing Community Paramedic services is essential. The Physician Medical Director for the EMS Service will oversee the continuing education and training that is required for each individual program. The continuing training and education will be based on the education plans filed with the EMS Board and DHHS. Continuing competency may be specific to the type of program and services that are being fulfilled. The physician may require specific skills and/or providers to go through formal education that exists for Community Paramedicine.

18. What requirements must the practitioner meet before his or her credentials may be renewed?

The EMS Services that provide Community Paramedicine should be evaluated during their regularly scheduled inspection on the status of their program, education, provider competency, and compliance with Nebraska Statutes and Rules and Regulations. EMS personnel should maintain the education
needed to provide the specific service(s) within the Community Paramedicine program at the direction of the Physician Medical Director.

Regulations in Other States

19. Identify other jurisdictions (states, territories, possessions, or the District of Columbia) wherein this occupation is currently regulated by the government, and the scopes of practice typically for this occupation in these jurisdictions.

There is a large variation of how other jurisdictions have regulated this practice. The National Association of EMS Officials has surveyed all states and the regulations and other information can be obtained by clicking here or at the below URL:


Additional Questions about this Proposal

1. What is the problem created by not regulating the health professional group under review, or by not changing the scope of practice of the professional group under review?

Many states have already recognized the need to enhance scope of practice, provide oversight, and maintain competency for Community Paramedic programs. Nebraska has an opportunity to establish minimum standards for Community Paramedic services and personnel and help establish a means to fill gaps in healthcare that is needed by patients. The Mobile Integrated Health – Community Paramedicine concept is a patient-centered approach that looks at a wide range of health care professionals to help patients by adding health care staffing resources that are needed throughout the State of Nebraska, including rural areas with limited access.

2. If the proposal is for the regulation of a health professional group not previously regulated, all feasible methods of regulation, including those methods listed below, and the impact of such methods on the public, must be considered. For each of the following evaluate the feasibility of applying it to the profession and the extent to which the regulatory method would protect the public.

   a. Inspection requirements

      The Nebraska Department of Health and Human Services, Emergency Health Systems, currently conducts inspections for compliance for EMS services and providers. These inspections would continue and provide criteria for those providing Community Paramedicine services.

   b. Injunctive relief

      Court ordered action is not necessary to address professional regulation in this instance. Development of statutes and subsequent promulgation of rules and regulations will achieve necessary oversight.

   c. Regulating the business enterprise rather than individual providers

      Emergency Medical Services are currently structured to regulate both service and individual provider responsibilities. Community Paramedicine programs would involve regulation of the EMS agency and the individual care provider. Such a model is common throughout healthcare. Hospital and clinics are regulated as are the professional care providers working within these organizations.
d. **Regulating or modifying the regulation of those who supervise the providers under review**

It is the intent of the Nebraska Credentialing Review Program to help determine the need for additional professional regulation. This application supports and recognizes the need to proactively regulate EMS services that will be providing Community Paramedicine services to maintain minimum standards based upon current medical evidence.

e. **Registering the providers under review**

Not applicable.

f. **Certifying the providers under review by the State of Nebraska**

The applicants would prefer to utilize an endorsement process to regulate Community Paramedicine EMS services and providers in Nebraska. The Nebraska Uniform Credentialing Act does not have a provision allowing for endorsement. Registration, Certification, or Licensure is the options available to the applicant group.

In Nebraska, certification (71-6206) is defined as: “Certificate or certification shall mean a voluntary process by which a statutory regulatory entity grants recognition to an individual who has met certain prerequisite qualifications specified by such regulatory entity and who may assume or use certified in the title of designation to perform prescribed tasks.” Certification provides a means to require minimum standards for education, rendering of critical care transportation services, establishment of ongoing competency requirements, and holds practitioners accountable to standards of professional conduct.

g. **Licensing the providers under review**

Not applicable.

3. **What is the benefit to the public of regulating the health profession group under review or changing the scope of practice of the regulated health profession under review?**

Currently there are no minimum standards governing the provision of Community Paramedicine services within Nebraska. As a result, programs could be created that do not ensure minimum patient care standards are being met, that minimum oversight requirements are established, or assuring initial and ongoing training and education of providers is occurring. This also creates opportunities to eliminate gaps in healthcare services, improve patient care, and reduce healthcare costs.

4. **What is the extent to which the proposed regulation or the proposed change in scope of practice might harm the public?**

The proposed changes do not harm the public. Mobile Integrated Healthcare – Community Paramedicine programs show an increase to the care, health, and safety of patients as well as showing decreased costs to patients, Medicare, Medicaid, and insurance companies. Failure to support this initiative may result in continued or expanded gaps in communities and patients not receiving the care they need.

5. **What standards exist or are proposed to ensure that a practitioner of the health professional group under review would maintain competency?**

The Nebraska EMS board currently has oversight of EMS services, providers, and protocols. Each service participating in Community Paramedicine programs will be required to have a system in place to evaluate the competency of their providers under the direction of the physician medical director.
and subject to EMS Board and DHHS review. Competencies should be developed by the Physician Medical director and approved by the EMS Board and DHHS.

6. What is the current and proposed role and availability of third-party reimbursement for the services provided by the health professional group under review?
Currently the biggest challenge for Community Paramedicine programs is the lack of financial support. According to the Mobile Integrated healthcare and Community Paramedicine (MIH-CP) 2nd National Survey (Appendix A), approximately 44% of the respondents in the NAEMT National Survey report the programs do not generate revenue with 36% of the programs being grant supported.

Programs have been making strides in funding. In some cases, state Medicaid programs will reimburse Community Paramedic programs for specific services. According to the Mobile Integrated healthcare and Community Paramedicine (MIH-CP) 2nd National Survey (Appendix A), many partners “including hospitals, home health agencies, hospice agencies, Medicare/Medicaid managed care organizations and private insurers have entered into contractual arrangements with EMS to provide these services.” In addition, in January 2018, these programs had a significant achievement when Anthem BlueCross BlueShield started to pay for non-transport services in 14 states including California, Colorado, Connecticut, Georgia, Indiana, Kentucky, Main, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin. (Appendix A)

7. What is the experience of other jurisdictions in regulating the practitioners affected by the proposal?
Identify appropriate statistics on complaints, describing actions taken, etc., by jurisdictions where the profession is regulated.
There is a large variation of how other jurisdictions have regulated this practice. The National Association of EMS Officials has surveyed all states and the regulations and other information can be obtained by clicking here or at the below URL:

8. What are the expected costs of regulating the health professional group under review, including the impact of registration, certification, or licensure on the costs of services to the public? What are the expected costs to the state and to the general public of implementing the proposed legislation?
Emergency Medical Services are already regulated in Nebraska, though not specifically CP services. The cost of regulation is not expected to increase. The infrastructure is in place that would minimize the impact of monitoring CP services and providers.

The Nebraska Department of Health and Human Services (DHHS), including the Emergency Health Systems program and Licensure Unit, currently regulate and license EMS services, personnel, and training programs. The Nebraska Board of EMS is composed of volunteer members who provide subject matter expertise, advising and collaborating with DHHS. The structures are in place within DHHS already which will keep costs to the state at a minimum. Under the Nebraska UCA, the certification process would align with other EMS certification and licensure processes. Currently, no EMS personnel are assessed any fee for licensure, and it is expected to be the same for any potential Community Paramedicine certification or licensure.
Costs to services and providers would be hard to determine as it will be dependent upon any additional training and/or equipment needs. However, the public should see a cost savings depending on the program and funding sources. One of the largest savings has been a decrease in the repeat users of the Emergency Department. This frees up EMS services to handle life-threatening emergencies as well as hospital staff to dedicate their time and resources to the patients that truly need an emergency care and not using it as a source of primary care.

9. Is there any additional information that would be useful to the technical committee members in their review of the proposal?

The National Association of State EMS Officials with the Ramsey Social Justice Foundation provides a resource (archive) of the latest published MIH-CP articles and the latest news for MIH-CP.

The archive for Community Paramedicine Articles may be found here: [http://www.ramseyfoundation.org/category/community_paramedicine_articles/](http://www.ramseyfoundation.org/category/community_paramedicine_articles/).

The archive for Community Paramedicine News may be found here: [http://www.ramseyfoundation.org/category/news/](http://www.ramseyfoundation.org/category/news/).

Pilot CP programs in Nebraska have seen a large success and Appendix E includes letters of support from affiliated hospitals and programs.

The National EMS Scope of Practice Model is currently under revision and has released a prepublishation draft copy for use by regulators. The updated Scope of Practice Model updates the concept of out of hospital settings as well as other profession related changes. This document is a supplement document and not an attachment due to its size.
Appendix

Appendix A: Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey

The document was not included in this application due to the length.
The survey can be found by following this link:
Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey
Appendix B: National EMS Scope of Practice Model – National Highway Traffic Safety Administration

The document was not included in this application due to the length. The survey can be found by following this link: Mobile Integrated Healthcare and Community Paramedicine (MIH-CP) 2nd National Survey https://www.ems.gov/pdf/education/EMS-Education-for-the-Future-A-Systems-Approach/National_EMS_Scope_Practice_Model.pdf
Appendix C: National Association for Emergency Medical Professionals MIH-CP Roundup
The final day of the NAEMSP annual meeting featured a half-dozen rapid-fire morning presentations on various aspects of mobile integrated healthcare/community paramedicine.

**Medical direction**—NAEMSP President Brent Myers, MD, began with a look at medical direction for MIH-CP programs. He broke it down by three basic approaches: the traditional method of standing orders, protocols, and online medical control; the emerging nontraditional approach in which medics are joined by other professionals and can receive guidance from non-EMS physicians; and a nascent PA/nurse practitioner-style model whereby community paramedics consult with medical direction but can practice more or less independently.

Traditional models can still be found in a lot of MIH-CP programs: MedStar’s diuresis protocol, Wake EMS’ high-risk refusal procedure, and Reno’s urgent-care protocol are examples. Where interprofessional teams function under this framework, integration must be purposeful and thorough. Arrangements can vary; Myers cited one system in Florida where medics actually supervise nurse practitioners. “Interprofessional teams can be assembled and operate in the real world,” he assured attendees, the large majority of whom had or were planning MIH-CP programs in their agencies.

A bit more novel is EMS providers working directly with patients’ primary care physicians. This can present a different challenge: Medics are used to giving reports to ED docs in a certain way, but primary care docs will likely have different questions and concerns. Here again it’s important to sit down and get on the same page before you take flight. Myers’ system, Wake EMS in North Carolina, created an arrangement with a primary-care group to treat simple-fall patients from assisted living. The program has reduced falls by 50% with no negative outcomes.

The PA/NP model is still rare, Myers said, but warrants consideration in how we consider MIH-CP medical direction in the future.

**Sustainability**—MedStar’s Matt Zavadsky, president-elect of the NAEMT, spoke on the financial sustainability of MIH-CP programs. He cited the NAEMT’s newly conducted second survey of such programs and noted that many more systems are now acknowledging their costs. Forty percent of those respondents reported having no financial support for their programs beyond grants.
That challenges programs to demonstrate their value to a range of potential payers who might be convinced to fund programs. That includes hospitals, home health, IPAs, hospice groups, post-acute care agencies, third-party payers, ACOs, and managed-care organizations. State-level Medicaid programs can be among the most agile payers, Zavadsky noted, because they don’t require Congress to act. Some states (Arizona, Minnesota, Nevada, New Mexico) are now paying EMS that way to treat and refer select patients to destinations besides emergency departments. Private insurers are also beginning to pay for such services.

“The payer’s perception of value is really the most important part of this,” Zavadsky said.

Palliative care—Alix Carter, MD, of Canada’s Dalhousie University, addressed an MIH approach to palliative care. Of palliative-care patients, she said, 70% want to spend their dying days at home, raising a need for ongoing care in that setting. Palliative approaches can reduce both costs and aggressive interventions—a valuable role for community paramedics.

Challenges in this area include protocol alignment, medics not knowing their patients, and a lack of clarity in care goals. So when Nova Scotia’s emergency service began its palliative care program in 2015, it required writing practice guidelines focused on symptom management, broad educational groundwork, and a program for managing special patients (managed through a database of patient wishes). The province’s medics strongly believe palliative care ought to be among their activities, Carter said.

Psych patients—Kevin Mackey, MD, medical director for California’s Mountain-Valley EMS, shared the results of a CP psych clearance pilot being conducted in Stanislaus County. Community medics there can refer patients without other medical problems directly to psych facilities. Of the first 1,000 patients treated under the pilot, 285 were eligible for and accepted for such referral, and just 12 had to be sent to emergency departments within the first six hours. Reasons involved behavioral changes, blood pressures out of the psych facility’s acceptable range (EMS’ range was broader), and lack of needed treatments like CPAP.

Of those 12, however, 5 were discharged home and 7 returned to psych care. None had to be admitted to a hospital because of an acute medical problem, meaning medics had correctly screened the sick from the not-sick. That proved the program could be run safely, Mackey said, but improvements were needed in communication with the psych facilities, data exchange, CP turnover, and facility management understanding the potential savings.
Continuing education—Dan Swayze, DrPH, of the Center of Emergency Medicine of Western Pennsylvania, addressed continuing education for MIH programs. He broke down the need by the three familiar domains of Bloom’s Taxonomy: cognitive (what do providers need to know?), affective (what should they value, and how should they act?), and psychomotor (skills performance).

Things like patient assessment and triage fall under the cognitive domain. Swayze and colleague Anne Jensen developed a mnemonic for assessing the needs of community paramedicine patients, CP MERITS. This stands for:

- Clinical
- Psychological
- Meals (do patients have adequate food?)
- Environment (what is their housing situation?)
- Records (some lack even the basic ID needed to apply for various programs and assistance)
- Income
- Transportation and
- Social support.

These areas are among the social determinants of health that can make a big difference in patients’ lives.

Triage in the CP setting, Swayze suggested, may be better approached by evaluating a subject’s situation as ideal, sustainable (not perfect but working for now), unsustainable (for example, about to lose their home), and immediate (e.g., homeless). Systems of care encompass system structure (knowing the hours, services, enrollment needs, insurance policies, etc., of assistance organizations), culture (knowing the “languages” of different stakeholders; not everyone defines emergency the same way), and craft (knowing, for instance, that one person at a partner organization may be helpful and reliable while another is less so).

The psychomotor domain of MIH-CP may involve using new devices and performing new tasks like obtaining blood or urine samples. The affective domain, meanwhile, is the most important but also the most overlooked. CPs require a therapeutic rapport with patients, professional boundaries (CPs have been known to give needy clients their own money or property), and alertness to signs of compassion fatigue (which inevitably results without those well-defined boundaries).

The time you spend on MIH-CP con ed is up to you. Useful methods include review of QI data and use of standardized patients. But if you’re wondering where to begin, Swayze related a question posed to him by
EMS legend Walt Stoy, director of the University of Pittsburgh’s emergency medicine program: If you had
to lay off half your CP workforce, whom would that be, and why? Swayze’s reasons included poor
documentation, poor communication skills, and lack of followup.

That, Stoy told him, is where to focus your con ed.

High utilizers—Finally, Kevin Munjal, MD, looked at pitfalls in evaluating high-utilizer programs. He cited
three studies that showed reductions in ED use and EMS transports by patients in such programs but
noted that all three evaluated just one group of subjects. This raised the possibility, he said, that results
were skewed by the common statistical phenomenon of regression to the mean.

What that means is that a variable that’s extreme on first measurement will tend to be closer to the
average on subsequent measurements. In other words, a dramatic decline in EMS/ED use may be less
dramatic when measured again.

This, Munjal said, can affect any research where the selection variable (e.g., being a high utilizer) is the
same as the outcome variable being measured. There are three ways to compensate:

- Add a comparison group;
- Take more measurements before and after;
- Stagger introduction of your measured intervention so study cohorts are their own control.

For more on NAEMSP annual meeting presentations, see http://www.naemsp.org/Pages/2018-Annl-Mtg-
Attendee-only.aspx.
Appendix D: Veteran paramedic pairs community paramedic, mental health specialist in new response model
Veteran paramedic pairs community paramedic, mental health specialist in new response model

Julie Lahr, who has been in EMS for 16 years, said she started thinking outside the box after realizing the impact community paramedics and mental health specialists could make in the field.

Apr 24, 2018

Sometimes, the best medicine is taking the time to look a patient in the eye and let them know that you care for the brief amount of time you spend with them during transport.

That’s one poignant thing Julie Lahr took from paramedic school.

"That particular seed of patient care was planted years ago and has been growing in me ever since," Lahr said.

Lahr, who has been in EMS for 16 years, worked as a reserve firefighter-EMT in Borrego Springs, Calif., for two years and then worked as a single-role paramedic in San Diego for eight years. She later moved to Texas and worked for Williamson County EMS as a paramedic for a year.

"I always felt less fulfilled as a paramedic when I never knew what happened to the patients I took to the ED," she said.

Lahr took interest in and joined the community paramedic program with Williamson County EMS—where she says she found out what really made people tick. She spent a year learning the ropes of the program and figured out very quickly that she would have to change her previously-learned way of thinking.

"It was quite a shift to spend so many years encouraging people to go to the hospital to then find yourself in a position where you’re working your tail off to figure out how to keep people from calling 911 and going to the hospital," she related.

During that time, Lahr found herself managing many patients with a mental health diagnosis. This eventually led her to the Mobile Outreach Team (MOT) for assistance.

"After about a year, MOT had a position with their community paramedic program managing high utilizers with a primary mental health diagnosis," she said.

It was then that she realized a newfound passion.

She worked as a community paramedic with MOT for three years before being inspired to create M&M-Medical and Mental Health.

A NEW MODEL

M&M-Medical and Mental Health, Lahr explained, is a 911 response model pairing a community paramedic and a mental health specialist.

While working for MOT, Lahr said she immediately noticed the important work mental health specialists were doing, and "the powerful, compassionate way they were having success managing the same patients I found so much frustration with. I knew there had to be a better way of doing business."

Due to the small size of the MOT team and extended response times, calls were generally routed directly to the ED due to time constraints once EMS arrived.

"It was a matter of getting the mental health crisis teams' tool box more directly and succinctly into the medical response of EMS," she said.
Lahr used successes from Wake County, N.C., and the CAHOOTS team in Portland, Ore., as inspiration while building the M&M response model.
"We had a round hole and a round peg; we just needed a coordinated operator to put them all together."

**HOW THE PROGRAM WORKS**

M&M pairs one MOT community paramedic and one mental health specialist in an emergency response SUV with code 3 capabilities. The team self-initiates and can be requested by EMS crews.

The goal of the M&M unit is to arrive within 10 minutes of the EMS crew's arrival. During this window, EMS can identify patients who don't have a primary medical complaint that requires a trip to the ED. Once confirmed, the M&M unit then releases the EMS unit back into the system. The mental health specialist performs a mental health assessment and provides the best course of treatment.

"This can be anything from a patient staying home with a safety plan, a tele-psychiatry appointment provided by the team or direct transportation and admission to a psychiatric hospital for in-patient treatment," Lahr noted.

Prior to initiating M&M, Lahr created a partnership with a local psychiatric hospital and wrote expanded medical protocols. The protocols allowed the MOT community paramedics to medically clear in the field by bypassing the initial EMS transport and multiple hours to days in the ED waiting for a bed at the psychiatric facility.

The M&M unit is able to identify patients who need follow-up stabilization and enroll the patients directly into the MOT community paramedic program for continued wrap-around care.

**M&M PROGRAM SUCCESSES**

The initial pilot program, Lahr said, was funded by the blood, sweat and tears from a small, dedicated team of MOT community paramedics and mental health specialists.

Feedback from the program has been overwhelmingly positive, Lahr said. Once word began to spread, the team started getting requests directly from fire and law enforcement.

"One of the municipal fire departments were so impressed with the work M&M was doing in their community during the pilot that they requested to partner with the MOT M&M unit and have dedicated time in their city," Lahr explained.

A survey was also sent to the EMS crews that M&M responded with, and the program received a 100 percent satisfaction score during their six-month pilot.

"You guys are what have been missing in field patient care for the 20 years I've been doing this," a Williamson County paramedic said in their survey feedback.

A major success of the program, according to Lahr, was the high level of EMS, ED and jail diversion. "This led to a huge cost savings for patients, first responders, the county and the hospitals," she said.

The unit, which has been absorbed into the MOT department, is running five days a week in partnership with a municipal fire department.

"Most importantly, in my mind, an often overlooked and under-treated demographic of the community is now getting the right help, resources and assistance they need the first time around."

The unit helps identify patients that are struggling and in crisis in the field and breaks the cycle of "EMS-ED-discharge, EMS-ED-discharge," Lahr said.

"One of our first days in the pilot, I had a patient who had been to the ED two times prior that week with the chief complaint of suicide. The patient was discharged with a follow-up with your doctor plan. The third time he called 911, M&M responded and was able to get him direct access to the correct resources and break that cycle."

**M&M PROGRAM ROADBLOCKS**
While there have been many documentable successes of the program, there have naturally been some bumps and bruises along the way. Staffing, Lahr mentioned, has been their biggest roadblock while implementing the program. "MOT was a small team to begin with; staffing the pilot and continuing other current responses and duties was challenging. Creating a mutual respect for clinical judgement and a common language between community paramedics and mental health professionals was something that was necessary." Funding was also a sore spot for the program, but Lahr said it has finally fallen into place. The biggest headache, however, was charting and data tracking. "We were charting in three different software platforms due to having a full mental health chart, a full EMS chart and follow-up care in our MOT program. This was a lot of extra work and quite maddening for data tracking."

Every new program, Lahr said, comes with challenges and roadblocks. However, she said what keeps her going is the supportive nature of community partners, as well as her community paramedics and mental health specialists. Lahr received the Dynarex First Responder Caring Award for developing and implementing the program. (Courtesy photo)

POSITIVE FEEDBACK

The program, Lahr said, has been powerful in more ways than one. "It has been pretty magical working alongside each other as a more intimate, succinct team responding in the 911 system. I have been in awe of the way the mental health specialists have been able to command a scene, connect and diffuse patients that were about to get ketamine ... or the compassion in which they can sit with an actively suicidal patient and spend the time needed to inspire that one glimmer of hope that's needed for the patient to agree to go directly to an in-patient facility for help."

In turn, Lahr has received a lot of feedback from the mental health specialists. "They say that they felt so much more at ease having a community paramedic at their side to rule out any number of medical possibilities, allowing them to really focus on a mental health evaluation and best course of action." For Lahr, it has been powerful to have "such different pairs of glasses to look through with one common goal."

DATA, DATA AND MORE DATA

Departments looking to incorporate or start a similar program at their agency or department must be data-driven, Lahr explained. "Identify how many calls in the system are not suited for an ED or don't need an EMS unit," she said. "Figure out what kind of calls those are and then who would be best suited to respond to them."

Lahr also said that it's vital for departments or agencies to spend time researching behavioral health resources in their area or jurisdiction. "Talk to them, ride out with them, shadow them; get a true understanding of how they work and how they could potentially fit into the program you're trying to solve," she advised.

And candy doesn't hurt when it comes to launching collaborations. "We named our unit M&M; and yes, we took M&Ms everywhere," Lahr said. Another piece of advice from Lahr: don't be afraid to start small. "Whatever amount of work you can do, do it really well." M&M, she said, started with one 12-hour day a week.
"Work hard to find providers that are willing to get out of their comfort zone and do something different. Put them all in a room and let them duke it out; then create something positive and powerful," she advised.

At the end of the day, Lahr said it's important to also know your boundaries. "Our team wanted to help with everyone and everything that wasn't a medical call that didn't need to go to the ED. We quickly realized while we can help with a lot; we cannot help with everything." When starting a program, Lahr said tracking data is king. "Data, data, data. Did I say data? Get the numbers, put dollar signs on it and get that info out with a megaphone."

And when numbers start to overwhelm or take precedence, Lahr said it's important for agencies or departments to remember about the human component of responders. "This line of work is not like field paramedic work. It's a very different animal to some degree; it taxes providers mentally and emotionally."

She recommended that EMS leaders be proactive with their teams by having debriefing support and check-ins. "Learn about self-care and promote the heck out of it. When every call you run is heavy and can be quite dark, there needs to be a strong support in place."

At the end of the day, Lahr said she hopes to see some sort of alternate destination response become more commonplace in EMS. "EMS is exceptional at cardiac arrests, strokes and diabetic emergencies ... sadly, those end up being a smaller population of the calls. As first responders, I think we have room for improvement on many of the other calls, such as suicide, anxiety, psychosis ... even the 'I don't feel good' for the third time in a day calls."

Lahr's main goal is to put together curriculum for a mental health paramedic specialty – similar to a critical care or tactical paramedic. "I would love to see more M&M response models in communities. Mental health is something the general paramedic curriculum doesn't prepare providers for, for the amount of mental health we respond to in the field. The world is changing; the amount of violence in our society that comes from isolation, depression and any number of imbalances is acutely tangible and out in the open in our faces."

For departments or agencies implementing or starting a similar program, Lahr hopes to also see more first responders becoming problem-solvers. "We need to dig deeper into our roles in the community and find ways to provide preventive interventions we could all embrace."
Appendix E: Pilot Program Support Letters
To Whomever It May Concern:

Regarding: Partnership with CHI Health Immanuel and Community Paramedics-Medics At Home (MAH)

This letter is in support of the partnership with CHI Health Immanuel and the Community Paramedicine Program, Medics At Home. This partnership began in 2014. The goal of this partnership was to keep medically high risk patients in their homes (at their request), once discharged from the ED or hospital stay. The objectives we had identified were:

- Decrease ED visits
- Reduce readmission to hospital
- Increase referrals to home care, if indicated and appropriate
- Improve patient satisfaction with entire discharge process from hospital to post acute setting

Upon review of our initial data, it was determined to expand the program to include patients with diagnoses of COPD, Pneumonia, and Heart Failure, and include other CHI Health metro facilities. Paramedics were able to assist with several post-discharge functions, including:

- Assessment including vital signs
- 12-lead EKG if applicable
- Blood glucose if applicable
- General discussion on well-being
- Communicate gaps identified to hospital care management team
- Home environmental safety check

There were many learning opportunities identified in this partnership. Having MAH identify challenges and then the ability to communicate with the patients provider, was key for transitioning patients successfully from the hospital to home.

Another great asset to this program is the ability for the paramedics to see the patients the day they are discharged from the hospital, or the following morning. This is especially helpful for those patients who get home, and now have questions regarding their respiratory equipment, or are just anxious regarding their recent discharge.

The Community Paramedic staff are awesome to work with. They are represented at our hospital readmission meetings, and provide valuable information that helps to evaluate the effectiveness of our care coordination, and identifies opportunities for us to improve these transitions home.
Our readmission rates have improved while utilizing the Community Paramedic program. Readmission rates average around 12-14% for PN/COPD population while using MAH services, compared to 17-20% nationally. Heart failure readmission rates average 15-17%, while nationally is 21-25%. CHI Health Immanuel averages 20-35 referrals per month.

Having the support of the MAH team has been a huge satisfier to our patients as well. We look forward to continuing to work with this great team!

Sincerely,

Kathryn Koehler
CHI Health Immanuel
Vice President Patient Care Services
To: Whom it May Concern

From: Adam Vossen M.D.
Medical Director
Immanuel Pathways PACE

RE: Medics at Home

I wanted to take this opportunity to voice my support for the Medics at Home community paramedicine program and endorse their efforts to obtain a broader base of insurance coverage in the state of Nebraska. Immanuel Pathways PACE (Program for the All-inclusive Care of the Elderly) has been working with Medics at Home since I was hired by Immanuel in September 2015. The PACE model is a permanent CMS model of care that combines Medicare and Medicaid resources to deliver care to adults who are 55 years of age and older, who reside in our service areas, qualify for long term nursing home level of care and want to remain living in their own homes. The community paramedicine services that Medics at Home has been able to provide to our participating members has been invaluable in helping them achieve their goal of continuing to live in the communities we serve for as long as possible.

By utilizing the Medics at Home community paramedicine services that are available to us 24 hours a day, 365 days a year, our program is able to acutely address any urgent medical needs our participants have. This has allowed our participants to get the care that they need, at the time they need it without unnecessary trips into the Emergency Department or re-admissions to the hospital after discharge from an inpatient stay. Our medical providers can trust that the evaluations that are completed by the paramedics working with our participants will provide the information that they need to determine if a situation can be managed in the home setting or if transportation to a higher level of care is indicated. Our participants can trust that they will get the care that they need and that contacting EMS or pushing their lifelines and going to the Emergency Department is not the only way to have their acute medical concerns addressed and treated. The benefits of working with Medics at Home have been so great for our PACE program that our PACE center in Des Moines IA worked with ambulance services at Mercy Medical Center to approximate the same paramedicine services that Medics at Home is able to provide our participants with here in Omaha and Council Bluffs IA. This is the first community paramedicine program in the Des Moines area and we are so pleased to be able to support our participants in the Des Moines area the way that we can here with Medics at Home.

I am a firm believer in the utility of community paramedicine services and I am so thankful to Medics at Home for ensuring that we have these resources at our disposal.
If you have any questions or want further information about our program’s experience with Medics at Home please feel free to contact me anytime.

Respectfully,

Adam Vossen M.D.
Medical Director
Immanuel Pathways PACE