EMERGENCY MEDICINE®

EDITORIAL

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Back to the Future, Part 2: Community Paramedicine

Following the successful use of ambulances during the Civil War to transport wounded soldiers from the battlefield to safer and better equipped field hospital facilities, many communities adopted the practice for their civilian populations. Between the Civil War and World War II (WWII) "teaching hospitals" sent interns on their ambulances both to improve patient care at the scene, and to further their interns' postgraduate education. However, as described by Ryan Corbett Bell in his book *The Ambulance* (Jefferson, NC: McFarland; 2009), by the 1930s, relatively poor reimbursement for ambulance calls followed by the severe doctor shortage due to WWII, effectively ended this practice. Though the interns were initially replaced by "ambulance attendants" or "orderlies," since the 1960s, ambulances have been staffed by trained EMTs and (later) paramedics to provide basic and advanced prehospital care both at the scene and during transport. For almost half a century, paramedics operating with standing protocols and physician medical control have conclusively demonstrated their ability to improve care and save lives.

At present, the increased demand for access to medical care brought about by the Affordable Care Act, an aging homebound population, overcrowded EDs, and inpatient services filled to capacity, along with, in some areas, insufficient numbers of visiting nurses, NPs, and PAs to provide needed home care services, prompted many to consider expanding the role of paramedics and EMTs to provide "community paramedicine," without afterward requiring them to transport patients to hospitals.

Community paramedicine was defined in 2012 by the US Department of Health and Human Services Administration as "an emerging field in health care where EMTs and Paramedics operate in expanded roles in an effort to connect underutilized resources to underserved populations" (https://www.hrsa.gov). A standard curriculum consisting of 114 hours of education in social determinants of health, public health, and tailored learning about chronic diseases, together with 200 hours of laboratory and clinical experiences has been developed and made available free of charge to colleges and universities (https://www.ruralhealthinfo.org).

Among the many individuals and organizations weighing in on the subject of community paramedicine, the American College of Emergency Physicians 2015 policy statement supports the development of properly designed expanded scope of practice programs for EMS personnel with medical oversight, that do not compromise existing emergency response systems (https://www.acep.org/). Dr Bryan Bledsoe, an editorial board member of *JEMS* (*Journal of Emergency Medical Services*), provides a thoughtful analysis of the pros and cons of community paramedicine (http://www.jems.com), while Iyah K. Romm and colleagues, writing in the *NEJM Catalyst*, offer concrete evidence of the effectiveness of one such mobile integrated healthcare and community paramedicine program (http://catalyst.nejm.org).

Properly trained, experienced paramedics with careful supervision by emergency medical control physicians and consultation with the patients' primary care physicians, supported by telemedicine and bedside diagnostic tests, can provide essential care in a patient's home environment. Depending on local circumstances, EMTs and paramedics can provide that care 24/7, supplementing other available home health care to support posthospital-discharge care for congestive heart failure, wound healing, etc, obviating the need for repeated ED and clinic visits or hospitalizations.

In addition to patient benefits, community paramedicine offers an opportunity for experienced paramedics to extend their years of practice similar to the way urgent care clinics have enabled experienced EPs to extend theirs. For all of these reasons, we support an expanded role for EMTs and paramedics in safe, carefully planned community paramedicine programs.

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