JEMS
JOURNAL OF EMERGENCY MEDICAL SERVICES

jems.com

Published on *jems.com* (http://www.jems.com)

Argument Against Setting Standards & Rules for Community Paramedic Programs

Thursday, September 27, 2012
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A few nascent “community paramedic” programs dot the nation’s landscape. They are the subject of much conversation and great interest, because we (the EMS community) are anxious to shed our “one trick pony” status and provide services that are more appropriate and effective, and less costly than the “take everybody to the emergency department in an ambulance” model that’s predominant in the U.S. today.

There are some good ideas being tested to remove the focus from that model:

- Reduce the burden of “medical clearance” of individuals with mental health (but no emergent medical) needs prior to admission to a mental health facility;
- Reduce 9-1-1 calls from people with chronic diseases, such as congestive heart failure and diabetes; and

- Partner with hospitals and insurance companies to do health status monitoring to prevent hospital re-admissions, as hospitals begin to face financial penalties from Medicare when patients are readmitted soon after discharge.

There are other ideas, yet not a single peer-reviewed journal article has established that these programs add value to the community, despite the positive feelings they produce in those that are involved, both caregivers, clients or patients. In other words, there is as yet not a shred of evidence to support the community paramedicine concept. If we have started to understand anything in EMS, it is that we should base clinical care, as well as operational and human resources decisions (and everything else) where possible, on sound research; we know that we need to become evidence-based if we are to grow our professional credibility.

Nonetheless, there are many out there for whom the solution to any problem is the promulgation of a rule. Or, if you can't create a rule (or a law or regulation), then how about a standard published by an organization that exists to produce and publish standards? After all, state regulatory agencies arguably exist to protect the public from substandard care, and non-governmental standards-setting organizations exist to set standards that represent a consensus of the organization that they represent.

So What's the Issue?
The issue is that governmental rules, or privately promulgated standards, ought to be based on something more substantial than the opinions of those involved, whether elected or appointed, or the result of a "consensus process." Anything that's less than hard evidence, and we get the kind of rules and standards that can only be enforced or implemented with tongue firmly planted in cheek, such as the rule that tried to mandate, in the name of who knows what benefit, that all ambulances should be white with a stripe of Omaha orange. What's the point of that? Nobody knows, and nobody can find where the evidence for that proposed rule came from.

When the Floor Becomes the Ceiling
Community paramedicine, as a concept, is in its infancy, or perhaps more correctly, it's in an "embryonic" stage. Attempts to draw a box around this embryonic concept can only limit its development at the very time when it's trying to gain its feet, try out new concepts and gather enough evidence to establish its value.

Most regulatory efforts attempt to set a floor, beneath which those who are regulated shall not fall. This is a good concept, in theory. However, as we have seen many times in the EMS world (particularly in the area of education), what is conceived and promulgated as a floor becomes a ceiling. If an EMT course is supposed to be a minimum of 100 hours, when the budget for that course is set at a community college, the course is allocated enough of a budget for 100 hours and nothing more. In an instant, the floor becomes the ceiling. The same thing happens with vehicle specifications: try to buy anything beyond "the standard" and you've got a fight on your hands, particularly when fiscal times are tough.

Community Needs vs. Regulation
I've been observing the community paramedicine (CP) movement since its inception (and before, when our colleagues in the U.K. rolled out the "emergency care practitioner" concept). What a CP program does for its community must be uniquely tailored to the particular health needs of the community, and must be carefully integrated with the

healthcare systems, resources and agencies presented in that community. Failure to do so can mean the rapid demise of the program, because few such programs are strong enough, at birth, to withstand organized opposition from other players in the healthcare community. When regulated, without evidence to support those regulations, these programs will lack the flexibility to adapt and ultimately, to thrive. Training for community paramedics, whatever they are called, must similarly be custom-designed to train practitioners to work within their unique local systems, needs and resources. One distinction that is starting to be quite clear is that “community paramedicine” means something very different in a densely populated urban area than it does in a very rural or frontier community.

I’m not saying that the day won’t come when regulation of community paramedic programs and practitioners becomes necessary. Once there is a consensus about what constitutes a valid community paramedic program, and there is sound, peer-reviewed evidence to support or refute the perceived value, we may be close to that time. Once there is consensus about what the body of knowledge of a community paramedic should be, regardless of where he or she works, we may be ready to talk about a new level of licensure. However, none of this exists, and if we are in too big of a hurry to regulate community paramedic services, or to test or license community paramedics at the state level, then we will never reach the point of consensus. We will have strangled the embryo before it had a chance to develop.

Be Patient

I urge our colleagues in regulatory agencies, in standards-setting agencies and in associations that have the ability to influence regulatory and standards-setting processes, to be patient. The time for a regulatory tool within community paramedicine will come—but it’s not here yet.

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