Department of Public Safety

DEPARTMENT OF PUBLIC SAFETY

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163 MAINE EMERGENCY MEDICAL SERVICES SYSTEM

CHAPTER 19: COMMUNITY PARAMEDICINE

BASIS STATEMENT AND RESPONSE TO COMMENTS

Basis Statement:

This rule is intended to repeal and replace the existing Chapter 19 rule. This rule contains updated guidelines under which the Emergency Medical Services Board may issue a Community Paramedicine designation, agency license, and personnel licenses to an entity applying for such under M.R.S. 32 Chapter 2-B § 84 (4) Establishment of community paramedicine services.

Summary of the comments:

Maine EMS received five written comments from five members of the public.

General Comments	
Aaron Bostel	Having moved here a few years ago, I came from a state that utilizes MIH or CP programs. When I read through your proposed rules and regulations, it is apparent you put a lot of time, effort and thought into your proposed plan. I also see in the references you are following states such as Florida and California, both known for being on the forefront of CP programs. My concern, our state is nothing like either of these places. While your thoughts are well put together, the implementation seems near impossible for such rural isolated communities (which you reference isolation in your own plan). This state, especially the rural locations could greatly benefit from CP programs. I think you should focus efforts on regional training for MIH and increasing the number of providers that can help implement and sustain MIH programs versus regulating it into the ground. Your proposal seems like it will greatly limit the number of providers that are willing to participate in MIH, which is the opposite of what this state really needs. I am strongly in favor of education and continuing education, but if the state is going to propose a plan that includes oversight, you should also include plans for

	implementation and assist with initial training as part of your plan. Pointing out that one community college in Maine teaches a CP program is not near sufficient, especially as you yourselves point out how rural and isolated our communities are. Utilizing an EMS educator and offering weekly zoom classes, you could provide that training to providers throughout the state. Another consideration is medical direction, providers wishing to utilize CP programs should also be included in this training. This would help keep everyone involved on the same page. Thank you for your time. **Maine EMS's Reply** – Thank you for your comment. The Maine EMS Board is not making any changes as a result of this comment. The rule addresses the structure, licensing, and minimum standards. The operation aids, and guidance will be forthcoming.
Sara Ratcliffe	The Home Care & Hospice Alliance of Maine would like to register the following comments with Maine EMS regarding proposed changes to Chapter 19, Community Paramedicine rules. Alliance members recognize the beneficial support and services provided to patients within their homes by community paramedics. We further recognize that community paramedic services can support patients that may not qualify for other services such as home health care and can partner with home health and hospice agencies to support the most efficient delivery of care. This can reduce hospitalization and provide additional resources to help respond to subacute needs of patients. To that end, we support the efforts of Maine EMS to provide a process and requirements for licensure for community paramedicine in the State. In order to improve the proposed rule, we offer the following comments. During the legislative process that led to this proposed rule change, the Alliance noted that its members were concerned about how and where the lines are drawn between community paramedicine and home care. In general, home care providers want to maintain a delineation between home care services and community paramedicine. Providers are concerned about "creep" and whether the changes proposed in these rules could lead to some providing what are essentially home care services under the auspices of community paramedicine. Maine EMS and other key stakeholders made it clear that community paramedicine should be closely integrated with the State's system of home health providers to avoid this sort of "creep," enhance service delivery and mitigate negative outcomes for patients. We recommend that this integration be enhanced in the proposed rule by mandating referrals and eligibility assessments to home health agencies to ensure access to comprehensive in home clinical services. Community paramedicine providers can supplement skilled nursing services to strengthen care delivered in the home. Home health agencies provide in home telehealth and telemonitoring services throughout the State of Maine. We strongly encourage community paramedicine

	programs to establish a home care technology partnership, and the proposed rule should reflect this recommendation. In addition, the Alliance would like to express concern with specific portions of the underlying scope of practice for community paramedicine practitioners. In particular, we feel that wound care management (including complex wound care) and post-surgical ostomy care in the home are services warranting a nursing assessment and the clinical judgement of a professional nurse to evaluate wound progression/deterioration and status of medical, pharmaceutical and nutritional conditions that impact healing. We recognize that there are geographic locations in Maine where home care nurses are not available to provide services in the home. Wound care and post-surgical ostomy care should only be performed by a community paramedicine professional in the documented absence of RN services. We appreciate the opportunity to submit comments on this important rulemaking process. **Maine EMS's Reply** – Thank you for your comment. The Maine EMS Board is not making any changes as a result of this comment. An eligibility assessment is outside the scope of practice for a community paramedicine clinician. All community visits begin with a referral from a physician and this rule establishes the scope of practice and a continuous communication pathway with the referring physician. We support a home care technology partnership, mandating one would create an unfunded mandate within the rule.
Thomas Judge	25 September 2024 Thanks for all of your work on this important topic and good to see the CP/MIH concept progressively formally adopted in Maine. I appreciate the opportunity to comment. As background I started the first CP project with St. George EMS in 2011/12 and was one of the originators of the concept at the CP conference held at Dalhousie 2005. After using the Informed Community Self Determination model with Kevin McGinnis our service moved to incorporate CP as a means to assure 24 hour paramedic coverage in the community as we had low volumes of 911 calls but close to 28% of the population aged 65 or greater living at home, many with limited support structures and the PBMC emergency department and virtually all primary care located at a distance in Rockport. We already had some experience our earlier efforts in the early 1990's when working with the ED physicians at PBMC and primary care physicians we had started managing chronic heart failure at home for selected patients. Our design premise for the CP program, integrated with Kno-Wal-Lin Home Health and Hospice, was that if we could safely support 9 citizens who were facing increasing coping challenges living at home for nine additional months of the their lives the trade off in MaineCare costs would more than cover the cost of full time paramedic coverage in the community. The average person going into long term care in Maine, spends down all of their assets in about 13 months at which point they are a permanent MaineCare beneficiary for the remainder of their life. Obviously, budgets and reimbursement have not yet caught up with

	system design. Formalizing the CP system is a necessary step in a more integrated healthcare spend policy structure. I note the elderly at home issue as while each CP program will have a particular focus to meet community need supporting our frail elders in rural Maine is one of the most significant healthcare challenges facing Maine. Section 1. 1. Definitions. The term "episodic" has been widely used in describing CP programs but has specific references in other parts of healthcare particularly home health/ hospice where care is defined by numbers of visits. This may be useful in building synergy for reimbursement strategies for EMS and HH/ H but may not be the ideal term as this is primarily a reimbursement rather than care-based definition. **Maine EMS's Reply** – Thank you for your comment. The Maine EMS Board is not making any changes as a result of this comment, as the term "episodic" is used in the statute. Title 32 MRS §84 "4. Establishment of community paramedicine services. The board may establish community paramedicine services. As used in this subsection, "community paramedicine" means the practice by an emergency medical services provider primarily in an out-of-hospital setting of providing **episodic** patient evaluation, advice and treatment directed at preventing or improving a particular medical condition, within the scope of practice of the emergency medical services provider as specifically requested or directed by a physician." Section 1.2 "Episodic" is further defined and I am not sure this is entirely accurate. While we need to not engender any confusion between ongoing primary care physician relationships with an individual patient the EMS agency may in fact develop a multi-year relationship with a patient supporting social determinants of health and providing surveillance and referrals to other needed care through the patient's physician. I would recommend a bit of additional language in the CP definition in 1 and deleting this definition. **Maine EMS's Reply** – Thank you for your comment. The Maine EMS Board is not making any changes as a result of this comment, as the term "episodic" is used in the statute. 22 MRSA §2147, sub-§15 (A): "The care is episodic. For the purposes of this paragraph, "episodic" means an encounter with a patient focused on presenting concerns and an identified medical condition in which neither the community paramedic nor the patient has the expectation of an ongoing general home care relationship;" Section 1.9 Primary Care Medical Director means *a Primary Care Medical Director* means…. This language is redundant. I am also concerned "….practicing in a primary care capacity…" might be too limiting and actually preclude programs from advancing. Many of our hospitalists across Maine are Boarded Family Practice and Internists who might be interested in assisting at the community

	level. Similarly EM physicians who practice primary care every day and are closely aligned with the PCP's who generally work for the hospitals. We also have a large group these physicians stepping back from day-to-day practice who might also be really interested and helpful in assisting programs. **Maine EMS's Reply**—Thank you for your comment. Maine EMS has adopted the grammatical corrections, which do not change the intent of the language. The intent of the definition is to include any physician who practices or has practiced primary care regardless of their specialty. Section 2 Personnel licenses is a bit confusing in the numbering and conditional or full licenses. Are sections 2. 1 through 2.5 the full requirements for conditional licenses requirements for a full new license under this Chapter or does Section 2. 6 initiate the new full license level or does Section 2.3 initiate the full requirements anticipated under the Chapter. Is there an end date to the EMS clinician Conditional Licenses? Agencies are limited to November 2025. If the new full license level starts at Section 2.6 ▪ Section 2. 3 and 4. It is possible to combine these into a single section noting the license level and necessary qualifications. **Maine EMS's Reply** – Thank you for your comment. Maine EMS has adopted the suggested change, which does not change the intent of the language. ▪ Section 2.1.4. Suggest clarifying to "To be eligible to receive licensure per paragraph Section 2.1. **Maine EMS's Reply**—Thank you for your comment. Maine EMS has adopted the formatting changes, which do not change the intent of the language. ▪ Section 2. 2 and 5 are redundant and should be combined for clarification. **Maine EMS's Reply**—Thank you for your comment. Maine EMS has adopted formatting changes, which do not change the intent of the language. Section 2. 6. A. 2. Is this CP PCR's in the MEFIRS system or any PCR documenting activity by the EMS clinician? **Maine EMS's Reply** – Thank you for your comment. The Maine EMS Board is not making any changes as a result of this comment. The intent is to show current practice before adding an additional scope. Section 3. Scope of Practice. Section 2. 2 and 5 under conditional licenses whereas Section 3 identifies the full scope of practice anticipated with additional training. This should be clarified as to conditional or full license level. **Maine EMS's Reply** – Thank you for your comment. The Maine EMS Board is not making any changes as a result of this comment. Those conditionally licensed under the conditional license subsection may only provide community paramedicine according to the scope of practice for the level of licensure they are

	licensed at per Chapter 5 §2 and the level that the service is licensed at per Chapter 3 §XX Section 5. 5 Educational Requirements Community Paramedic. Is the 1800-hour requirement inclusive or in addition to original paramedic education at the Associate Degree level? The Education Standards identify the CP Associate Degree Program but note that other Associate or Bachelor's Degrees should be considered in addition to specific CP education. This is an important issue in Section 6. **Maine EMS's Reply** – Thank you for your comment. The Maine EMS Board is not making any changes as a result of this comment. This could be inclusive, but most likely, in addition to the applicant's original paramedic education. However, all will be compared to the Community Paramedicine Education Standards. Section 6. CP Agency Designation. As proposed the current Agency designations are only valid until November 2025. This may be barrier to EMS agencies already providing CP services as the time required to meet the new education standards will likely exceed the date. This is not an issue if conditional licenses for personnel are honored. **Maine EMS's Reply**—Thank you for your comment. The Maine EMS Board is not making any changes as a result of this comment. No deadline has been set for the expiration of conditional licenses. Section 7. CP Service Licensure. This incorporates a wide range of requirements that might be better to be separated into three sections. 7.6 Coordination. I would suggest a separate Section for 7.6 on the relationship and integration of the EMS agency providing CP services to other healthcare providers. This extends beyond home health to hospice, other community services, the local ED, etc. This issue is critical to the integration of healthcare and deserves a separate section. When we originated the Comfort Care Protocols many years ago we did not do enough outreach to our colleagues in home health and hospice with a result of increased rather than decreased friction for a time. This is an issue of substantial flux in the nursing profession and we need to make sure EMS is highlighting the importance of working tighter. One of our early successes in St. George was the close working relationship with Kno-Wal-Lin and PBMC. **Maine EMS's Reply** – Thank you for your comment. The Maine EMS Board is adding Hospice, other community and social services, and local ED providers to the rule as a result of this comment. Addressing Home Health coordination is a requirement of Title 32 §84(4-D). I would suggest Section 7.4 Patient Care Records and 7.5 Business Records be considered under a separate Section. **Maine EMS's Reply**—Thank you for your comment. Maine EMS accepts this comment and has moved these items to Section 10.

	7.4 With new technology to document and share CP interactions further thought should be given to the 24-hour upload PCR requirement. The upload to Maine EMS in 24 hours is consistent with other PCR's but there may be critical information gathered during the CP visit and interaction which should be documented to a standard and shared on a much timelier basis with physicians or other involved care givers such as home health and hospice. **Maine EMS's Reply** – Thank you for your comment. The Maine EMS Board is not making any changes as a result of this comment. The 24 hour period is a maximum, however individual agencies and clinicians may choose to make policies within a shorter timeframe to address this concern. 7.5.A The last sentence is redundant as record retention is noted as needing to meet all applicable city, state, and federal laws which require retention greater than 5 years. **Maine EMS's Reply**—Thank you for your comment. The last sentence has been updated to read: "The retention period for business records, contracts, and newspaper advertisements shall comply with the minimum requirements set forth by all applicable city, state, and federal laws, but in no case shall be less than five (5) years." 7.5 D. Personnel records. Should add requirement for continuing medical education relevant to CP as this is a rapidly changing practice. **Maine EMS's Reply** – Thank you for your comment. The Maine EMS Board is not making any changes as a result of this comment. The community paramedicine education standards outline continuing education minimums.
Jane Conrad	My name is Jane Conrad and I live in St. George, where we are fortunate to have had a community paramedicine program for many years. I first became aware of the community paramedicine program 8 or 9 years ago when my late husband, who had Parkinson's, required regular monitoring of his blood pressure after starting a new medication. It was tremendously helpful that a member of our community paramedicine team could come to our home to provide this care rather than undertaking the significant challenge of transporting my husband to Pen Bay, about 25 minutes from our home. In times when our healthcare providers are stressed to the max, when assisted living and nursing home care for elderly and chronically ill patients is scarce and expensive, and when Americans want to remain in their homes as long as possible, supporting community paramedicine programs to provide care close to home is a logical and cost-effective means of addressing some of those challenges. And, of course, such care should be reimbursed by insurance - whether that is MaineCare, Medicare, or private insurance. This is only fair to the program, but

	also helps support rural ambulance services like St. George's, where emergency responders are often on call or on duty merely awaiting the next 911 call. Support for community paramedicine is a win-win for all concerned - patients, caregivers, and taxpayers. I hereby express my gratitude for the St. George Ambulance and Community Paramedicine Program and encourage the legislature to do everything it can to provide reimbursement for such care, and to ensure that other towns in Maine have access to quality care in such a setting. **Maine EMS's Reply** – Thank you for your comment. The Maine EMS Board accepts this comment. The Maine EMS Board is not making any changes as a result of this comment. The board is grateful to hear stories about the positive impact of community paramedicine within the community.
Joe Kellner	Thank you for the opportunity to provide comment on the proposed rules for Chapter 19: Community Paramedicine. First and foremost, let me congratulate you all (as well as the MEMS office staff) on getting to this point. While I am a "bystander" when it comes to community paramedicine, I feel it is a very important and valuable step for EMS and can do wonders to augment care provided by other areas of the healthcare system, and arguably more importantly, provide patients an additional pathway to safely age in place. I have a few comments, which should be classified as "neither for nor against" the rule, which are offered in the spirit of improving the rule. As a global note, there are no licensing fees associated with a CP license. I think this is a mistake and continues a bad precedent. There is a lot of work on the side of the Maine EMS office, and that work is directly tied to supporting these programs, which does not benefit every service. There should be a reasonable licensing fee associated with becoming a community paramedicine entity. **Maine EMS's Reply** - Thank you for your comment. The Maine EMS Board is not making any changes as a result of this comment. The board anticipates that in the future there will be licensing fees associated with Community Paramedicine. Definitions Section, Line 13-15: Community Paramedicine programs have widely adopted the word "episodic" to describe the manner in which services are scheduled and delivered. The term episodic will cause, and has caused, confusion with Medicare certified Home Health Agencies. Home Health is delivered episodically, in that patients receives an episode of care, with that episode lasting a fixed length in time (usually 30 or 60 days). The only other place that Episodic appears in the rule is in the definition of Community Paramedicine. Because of the confusion this can create for patients and providers, potentially leading to a misunderstanding of the care to be delivered, I suggest updating this to be "Community Paramedicine Encounter," or simply "Encounter," which better fits the definition and will eliminate this issue. **Maine EMS's Reply** – Thank you for your comment. The Maine EMS Board is not making any changes as a result of this comment, as the term "episodic" is used in the statute. "4. Establishment of community paramedicine services. The board

	may establish community paramedicine services. As used in this subsection, "community paramedicine" means the practice by an emergency medical services provider primarily in an out-of-hospital setting of providing **episodic** patient evaluation, advice and treatment directed at preventing or improving a particular medical condition, within the scope of practice of the emergency medical services provider as specifically requested or directed by a physician." Line 42 contains a typo. "means a primary care medical director" should be deleted preceding "means a physician …" and the comma that follows this should be deleted. **Maine EMS's Reply**—Thank you for your comment. Maine EMS Accepts this comment. Maine EMS has adopted the grammatical correction, which did not change the intent of the language. Section 2(3) seems unnecessary. In the definitions, the CP levels have already been associated with MEMS licensure levels. It is unclear why the ascending order of the license is apropos to rule. **Maine EMS's Reply** - Thank you for your comment. The Maine EMS Board accepts this comment. The Maine EMS Board has merged these into one section. Line 107: Community Paramedicine Personnel should be a term defined in the definitions. When enforcing rule, the definition of personnel is often referenced, and it would help the board in the future if this were clearly defined. **Maine EMS's Reply**—Thank you for your comment. The Maine EMS Board accepts this comment. Maine EMS Has added a definition of Community Paramedicine Personnel to the definitions. "Community Paramedicine Personnel" means an emergency medical services person licensed as a Community Paramedicine Affiliate, Community Paramedicine Technician, or Community Paramedic. Section 2(6)(2), it should be clarified if this is referencing Community Paramedicine reports or standard MEFIRS patient care reports outside of the definition of CP. **Maine EMS's Reply**—Thank you for your comment. The Maine EMS Board accepts your comment. The Maine EMS board will clarify the language to: "must be documented in a caregiver role at the EMT, AEMT, or Paramedic level on at least 24 electronic patient…" Section 2(6)(A)(3) is a repeat of Section 2(4) **Maine EMS's Reply**—Thank you for your comment. The Maine EMS Board accepts your comment. Maine EMS has adopted these grammatical corrections, which do not change the intent of the language. Line 284: I would eliminate "looking to provide Community Paramedicine Services" from the sentence. It is colloquial in nature and unnecessary and is repetitive of the end of the sentence.

	Maine EMS's Reply—Thank you for your comment. The Maine EMS Board accepts your comment. Maine EMS has adopted these grammatical corrections, which do not change the intent of the language. Section 7(4), Line 365-369: A 24-hour charting requirement makes sense for 911 services. However, for CP, I would recommend a much shorter turnaround time for continuity of care. Notably, these patients (by definition) have a high risk of rehospitalization, and having the CP record available in Health Infonet would be extremely valuable in that continuity of care. I think four hours is appropriate. I would also note that this is listed under Section 7: Licensure but is not a licensing factor. It should be placed elsewhere within the rule as it is an operating rule, not a licensing rule. It should be moved to it's own section (I recommend Section 10: Patient Records). **Maine EMS's Reply**—Thank you for your comment. The Maine EMS Board accepts your comments referring to the location of the patient care reporting requirements. Maine EMS Has created Section 10: Patient Records and moved this language to that section. ***Add Previous Reply Here*** Section 7(5)(A): Business Records: Maine and federal statutes set very clear guidelines on record retention requirements, that I believe go beyond what is here. I suggest acting in deference to existing laws. **Maine EMS's Reply**—Thank you for your comment. The Maine EMS Board accepts this comment. The last sentence has been updated to read: "The retention period for business records, contracts, and newspaper advertisements shall comply with the minimum requirements set forth by all applicable city, state, and federal laws, but in no case shall be less than five (5) years." Section 8(1): This is fine, but it doesn't specific what happens if they have not provided CP once. I assume it means a new application, but this is unclear. **Maine EMS's Reply** - Thank you for your comment. The Maine EMS Board is not making any changes as a result of this comment. The Maine EMS Board anticipates that agencies that don't have at minimum one CP visit within the preceding cycle, but look to maintain licensure will come before the board for review.