**Selected Information from References Summarizing the Street Medicine and Community Paramedicine Interface as of May 2024**

Community Paramedicine: The term covers emerging models of care that are community-focused extensions of traditional emergency response model that has developed over the last 50 years. This new model of care calls on paramedics to apply their education, training and skills in “nontraditional” community-based environments and to embrace expanded scopes of practice. is an emerging field in health care where emergency medical service (EMS) providers, including emergency medical technicians (EMTs) and paramedics, operate in expanded roles to increase access to primary care and facilitate appropriate use of emergency care resources.

The concept of specialized non-transporting squads in EMS is a promising operational response to calls for advancing community paramedicine; better care for addiction, homelessness, mental distress, and food insecurity; and equitable public services to deliver innovative forms of prehospital care.

**The Emergency triage, treat and/or transport model (ET3)**

Medicare regulations have historically only allowed payment for emergency ground ambulance services when individuals are transported to hospitals, critical access hospitals, skilled nursing facilities, and dialysis centers. Most beneficiaries who call 911 with a medical emergency are therefore transported to one of these facilities, and most often to a hospital ED, even when a lower-acuity destination may more appropriately meet an individual’s needs.

In March 2020, CMS announced in a [press release](https://www.cms.gov/newsroom/press-releases/trump-administration-makes-sweeping-regulatory-changes-help-us-healthcare-system-address-covid-19) an Interim Final Rule with Comment Period (IFC) that provides temporary regulatory waivers and new rules to equip the American healthcare system with maximum flexibility to respond to the COVID-19 Public Health Emergency (PHE). For the duration of the Coronavirus-19 disease Public Health Emergency, CMS temporarily expanded the list of allowable destinations for ambulance transports. This began January 1st of 2021 and ended December 31st of 2023.

The Emergency Triage, Treat, and Transport (ET3) Model enabled ambulance teams to offer a person in need of less serious medical attention other options. These options included transportation to another medical facility to get care, such as an urgent care center, medical clinic or behavioral health center, depending on the person’s needs, or treatment with a qualified healthcare provider right where they were (in person or by telehealth). If a person was offered one of these options under the model, they could still ask the ambulance team to take them to the hospital. Treating people in non-emergency room settings may have saved them and their families time waiting in the emergency department and care may have been provided more quickly, hospital costs may have been avoided when appropriate, and ambulance teams may have focused on taking patients with the greatest emergency needs to the hospital.

The ET3 model ended early on December 31st, 2023 (2 years prior to scheduled performance period end date) due to lower than expected participation and lower than projected interventions. Under the model, CMS paid participants to 1) transport to an alternative destination partner, such as a primary care office, urgent care clinic, or a community mental health center (CMHC), or 2) initiate and facilitate treatment in place with a qualified health care partner, either at the scene of the 911 emergency response or via telehealth.

Total number of participants (EMS agencies) who have billed for ET3 Model Interventions: 72 (this is out of at least 12,000 separate EMS agencies participating in CMS across the USA).

To address long-standing health inequities, cities are segmenting services to deliver innovative forms of prehospital care. Examples include:

The Behavioral Health Emergency Assistance Response (B-HEARD) Division in New York City

* Not PEH-specific, but does include PEH

The Austin-Travis County EMS Community Health Program

* Includes PEH-specific programs in addition to other population-based programs

The Atlanta Mobile Integrated Health Advanced Practice Team

* Not PEH-specific (unclear if PEH are assisted by this program)

The San Francisco Community Paramedicine Team

* PEH Specific

Boston EMS Squad 80

* PEH specific

Portland Street response (Oregon)

* PEH specific

The southern King County (Washington State) Fire Department Community Assistance, Referrals, and Education Services unit

* Not PEH-specific, but does include PEH

**References/Resources:**

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M. Brennan et al. The policy case for designating EMS teams for vulnerable patient populations: Evidence from an intervention in Boston. *Health Care Management Science* (2024) 27:72–87.

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https://trainchicagoheart.org/paramedicine-in-ems.html

https://www.cms.gov/priorities/innovation/innovation-models/et3

National Highway Traffic Safety Administration EMS data:

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https://www.austintexas.gov/ems/innovations

https://communitycaretx.org/services/health-care-for-the-homeless/

https://www.sf.gov/street-medicine

https://sf-fire.org/our-organization/community-paramedicine

https://mentalhealth.cityofnewyork.us/program/b-heard

https://www.gradyhealthfoundation.org/mobile-integrated-health

https://www.portland.gov/fire/streetresponse

https://pugetsoundfire.org/fdcares/