



Community Paramedic

To address the critical shortages of health care professionals and services in rural and remote areas, the Community Healthcare and Emergency Cooperative is developing a Community Paramedic training program. The Community Paramedic will not replace existing health care services, but will fill the gaps revealed by examining each community. The Community Paramedic will ensure basic and advanced levels of care appropriate to prevention, emergencies, evaluation, care, triage, disease management, mental health and referrals. The Community Paramedic will receive standardized training—training that is consistent internationally—yet can be modified for each community, state and nation.

Role

The Community Paramedic will respond to identified health needs in underserved communities, ultimately improving the quality of life and health of rural and remote citizens and visitors. Roles will include outreach; wellness; health screening assessments; health teaching; providing immunizations; disease management, including a thorough understanding of monitoring diabetes, congestive heart failure and other high cost diseases and the methods and medications used to treat them; recognition of mental health issues and referral into the existing mental health care system; wound care; safety programs; and, functioning as physician extenders in rural clinics and hospitals in communities that have them.

Partners

Creighton University in Nebraska, Dalhousie University in Nova Scotia, the MNSCU Healthcare Education-Industry Partnership in Minnesota, the Mayo Clinic Medical Transport, the North Central EMS Institute, the state Offices of Rural Health in Minnesota and in Nebraska, and the University of Nebraska Medical Center formed the Community Healthcare and Emergency Cooperative in July 2007 to create a new community health provider model to serve rural and remote communities.

Status

The partners are working to create a Community Paramedic health care model, are writing a curriculum that builds on the MNSCU Community Health Worker curriculum and are planning a pilot of the model. The partners studied the Alaska Community Health Aide, the Nova Scotia Community Paramedic model, and the Australia Rural and Remote Paramedic Program. Each home grown project has something unique to offer. For example, Nova Scotia informally expanded the role of their paramedics in a three-phase process and demonstrated a 40 percent reduction in emergency room visits and a 28 percent reduction in clinic visits over five years.

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