

NFPA®

451

Guide for
Community Health Care
Programs

2020



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NFPA® 451

Guide for

Community Health Care Programs

2020 Edition

This edition of NFPA 451, *Guide for Community Health Care Programs*, was prepared by the Technical Committee on Emergency Medical Services. It was issued by the Standards Council on June 10, 2019, with an effective date of June 30, 2019.

This document has been amended by one or more Tentative Interim Amendments (TIAs) and/or Errata. See “Codes & Standards” at www.nfpa.org for more information.

This edition of NFPA 451 was approved as an American National Standard on June 30, 2019.

Origin and Development of NFPA 451

The first edition of NFPA 451, *Guide for Community Health Care Programs*, has been published after almost 5 years of development. The guide was originally requested by the International Association of Fire Fighters in 2013 because the concept of community paramedicine was spreading throughout the EMS industry, and EMS systems were searching for the best way to model themselves to meet the changing needs of their communities. At a time when the health care industry is undergoing major changes in the United States and throughout the world, the guidance in NFPA 451 is designed to add value, flexibility, and additional capabilities to EMS systems. Even the title of the document is designed for flexibility. While the systems for which this guide is designed are normally known as “community paramedicine” or “mobile integrated health care,” the technical committee felt that these terms were limited and that “community health care programs” better reflects the need to be versatile and to partner with other organizations in order to be successful. NFPA 451 can apply to any EMS system regardless of type, delivery model, or affiliation, and might even bring systems of different types together.

The technical committee thanks the EMS associations that participated in technical committee meetings and conference calls to support the development of this guide. They would also like to thank the National Highway Traffic Safety Administration (NHTSA) office EMS for their support and assistance.

Finally, the technical committee would like to dedicate this first edition of NFPA 451 to the memory of its late inaugural chairman and the person with whom the NFPA 451 project began, Kenneth R. Knipper. Ken was a visionary EMS leader representing the National Volunteer Fire Council on many EMS committees and projects. It was his passion that this guide be for any EMS system — fire-based, hospital-based, private, third service, volunteer, and so on — and that it encourage EMS systems to be innovative in their approaches in order to best serve their communities. Ken and his family are thanked for their hard work and inspiration.

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NFPA 451

Guide for

Community Health Care Programs

2020 Edition

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NOTICE: An asterisk (*) following the number or letter designating a paragraph indicates that explanatory material on the paragraph can be found in Annex A.

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Information on referenced and extracted publications can be found in Chapter 2 and Annex B.

Chapter 1 Administration

1.1 Scope. This guide provides direction for planning, preparing, implementing, and evaluating community health care programs to agencies supporting the emergency medical services (EMS) mission.

1.2 Purpose. The purpose of this document is to provide a framework for the design and evaluation of comprehensive community health care programs provided by local EMS systems, which may include disparate elements of government or the private sector.

Chapter 2 Referenced Publications

2.1 General. The documents or portions thereof listed in this chapter are referenced within this guide and should be considered part of the recommendations of this document.

2.2 NFPA Publications. National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169-7471.

NFPA 101®, *Life Safety Code*®, 2018 edition.

NFPA 1500™, *Standard on Fire Department Occupational Safety, Health, and Wellness Program*, 2018 edition.

2.3 Other Publications.

2.3.1 Other Publications.

Dye, R., and D. Merriman. “Tax Increment Financing: A Tool for Local Economic Development,” *Land Lines* (January 2006).

Merriam-Webster’s *Collegiate Dictionary*, 11th edition, Merriam-Webster, Inc., Springfield, MA, 2003.

2.4 References for Extracts in Advisory Sections.

NFPA 79, *Electrical Standard for Industrial Machinery*, 2018 edition.

NFPA 402, *Guide for Aircraft Rescue and Fire-Fighting Operations*, 2019 edition.

NFPA 901, *Standard Classifications for Incident Reporting and Fire Protection Data*, 2016 edition.

NFPA 1500™, *Standard on Fire Department Occupational Safety, Health, and Wellness Program*, 2018 edition.

NFPA 1521, *Standard for Fire Department Safety Officer Professional Qualifications*, 2015 edition.

NFPA 1561, *Standard on Emergency Services Incident Management System and Command Safety*, 2014 edition.

NFPA 1710, *Standard for the Organization and Deployment of Fire Suppression Operations, Emergency Medical Operations, and Special Operations to the Public by Career Fire Departments*, 2016 edition.

Chapter 3 Definitions

3.1 General. The definitions contained in this chapter apply to the terms used in this guide. Where terms are not defined in this chapter or within another chapter, they should be defined using their ordinarily accepted meanings within the context in which they are used. *Merriam-Webster’s Collegiate Dictionary*, 11th edition, is the source for the ordinarily accepted meaning.

3.2 NFPA Official Definitions.

3.2.1* Approved. Acceptable to the authority having jurisdiction.

3.2.2* Authority Having Jurisdiction (AHJ). An organization, office, or individual responsible for enforcing the requirements of a code or standard, or for approving equipment, materials, an installation, or a procedure.

3.2.3 Guide. A document that is advisory or informative in nature and that contains only nonmandatory provisions. A guide may contain mandatory statements such as when a guide can be used, but the document as a whole is not suitable for adoption into law.

3.2.4 Should. Indicates a recommendation or that which is advised but not required.

3.2.5 Standard. An NFPA Standard, the main text of which contains only mandatory provisions using the word “shall” to indicate requirements and that is in a form generally suitable for mandatory reference by another standard or code or for adoption into law. Nonmandatory provisions are not to be

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3.3 General Definitions.

3.3.1 Address. A number or other code and the street name identifying a location.

3.3.2 Alarm. A signal or message from a person or device indicating the existence of an emergency or other situation that requires immediate action.

3.3.3 Ambulance. A vehicle designed, equipped, and operated by approved personnel trained in the treatment of the sick or injured that responds to urgent, unscheduled requests for aid and/or transport of sick or injured persons.

3.3.4 Ambulance Service. An organization that utilizes approved personnel trained in the treatment and transportation (to an appropriate medical facility) of the sick or injured.

3.3.5* American College of Emergency Physicians (ACEP). A national organization of emergency physicians committed to advancing emergency care through continuing education, research, and public education.

3.3.6 Arrival. The point at which a vehicle is stopped at the scene of a response destination or address.

3.3.7 Arrived at Destination. The time that a responding unit arrived at the hospital or transfer point.

3.3.8 Automated Vehicle Locator (AVL). A computerized mapping system used to track the location of vehicles.

3.3.9 Available for Service. The time a unit is available for response.

3.3.10 Bloodborne Pathogens. Microorganisms that are present in human blood and can cause diseases in humans.

3.3.11 Call. A request for assistance to which equipment and personnel are deployed.

3.3.12 Call for Help. The time that a third party or a patient first attempts to contact outside assistance.

3.3.13 Call Intake. The procedure for answering the phone or other device that is used to receive a signal or message from a person or device indicating the need for medical assistance, learning the nature of the emergency, and verifying the address of the emergency.

3.3.14 Call Processing. The interval from call intake by the unit-dispatching agency to the time of unit notification, including answering the phone (alarm), gathering vital information, and initiating a response by dispatching the appropriate unit(s).

3.3.15 Chain of Survival. A metaphor to communicate the interdependence of a community's emergency response to cardiac arrest.

3.3.16 Compliance. Adherence or conformance to laws, regulations, and standards.

3.3.17 Cross-Trained/Dual Role (CT/DR). An emergency service that allows personnel trained in two service functions, such as fire suppression and emergency medical care, to function in either role.

3.3.18 Defibrillation. The delivery of an electrical shock to the heart intended to reverse abnormal electrical activity.

3.3.19 Defibrillator.

3.3.19.1 Automated External Defibrillator (AED). A device that administers an electric shock through the chest wall to the heart using built-in computers to assess the patient's heart rhythm and defibrillate as needed.

3.3.19.2 Manual Defibrillator. A device requiring operation by trained medical personnel that delivers an electric shock through the chest wall to the heart.

3.3.20 Deployment. The procedures by which resources are distributed throughout the service area.

3.3.21 Dispatch. To send out emergency response resources promptly to an address or incident location for a specific purpose.

3.3.21.1 Computer-Aided Dispatch (CAD). A dispatching method or process in which a computer and its associated terminal(s) are used to provide relative dispatch data to the concerned telecommunicator.

3.3.21.2 Emergency Medical Dispatch. The receipt and management of requests for emergency medical assistance in the emergency medical services (EMS) system.

3.3.22 Dispatch Time. A discrete time stamp that represents unit notification.

3.3.23 Documentation. The process of gathering, classifying, and storing information.

3.3.24 Emergency. A condition or situation in which a prudent layperson perceives a need for immediate response.

3.3.25 Emergency Medical Dispatcher (EMD). Emergency medical services (EMS) personnel specifically trained and certified in interviewing techniques, pre-arrival instructions, and call prioritization.

3.3.26 Emergency Medical Services (EMS). Providing patient services that might include the provision of assessment; treatment such as first aid, CPR, basic life support (BLS), and/or advanced life support (ALS); and other prehospital procedures, including ambulance transportation of patients.

3.3.27 Emergency Medical Services for Children (EMS-C). A national initiative to reduce child and youth disability and death from severe illness or injury.

3.3.28 Emergency Medical Technician (EMT). A term for any prehospital provider trained and certified at the EMT-Basic level or higher.

3.3.28.1 Emergency Medical Technician — Basic (EMT-B). A prehospital basic life support (BLS) provider trained according to the National Highway Traffic Safety Administration (NHTSA) National Standard Curriculum.

3.3.28.2 Emergency Medical Technician — Advanced (EMT-A). A prehospital provider trained according to the National Highway Traffic Safety Administration (NHTSA) National Standard Curriculum to intermediate levels.

3.3.28.3 Emergency Medical Technician — Paramedic (EMT-P). A prehospital provider trained according to National Highway Traffic Safety Administration (NHTSA) National Standard Curriculum to advanced levels.

3.3.29 Emergency Operations. Activities of emergency responders relating to rescue, fire suppression, emergency medical care, and special operations.

3.3.30 Employee Assistance Program (EAP). An EAP is an employer-sponsored service designed for personal or family problems, including mental health, substance abuse, various addictions, marital problems, parenting problems, emotional problems, or financial or legal concerns.

3.3.31 Employee Illness and Injury. A work-related illness or injury requiring evaluation or medical follow-up.

3.3.32 Employee Turnover. Termination of employment with the organization for any reason.

3.3.33 Fire Suppression. The activities involved in controlling and extinguishing fires. [1500, 2018]

3.3.34 First Intervention Time. The time that the first emergency medical services (EMS) skill intercession (e.g., starting an IV, defibrillation, CPR, or extrication) is begun.

3.3.35 First PSAP Call Time. The time the telephone (or other notification device or mechanism) activates in the first public safety answering point (or other designated entity).

3.3.36 First Responder (EMS). Functional provision of initial assessment (i.e., airway, breathing, and circulatory systems) and basic first-aid intervention, including CPR and automatic external defibrillator (AED) capability. [1710, 2016]

3.3.37 Governance. All related federal, provincial, state, and local laws, regulations, administrative requirements, and policies.

3.3.38 GSA KKK Specifications. A set of federal specifications issued by the General Services Administration (GSA) relating to purchasing requirements for ambulance design and manufacture.

3.3.39 Hazard. A source of possible injury or damage to health. [79, 2018]

3.3.40 Hazardous Material. A substance that presents an unusual danger to persons due to toxicity, chemical reactivity, decomposition, corrosiveness, explosion or detonation, etiological hazards, or similar properties.

3.3.41 Health Care Financing Administration (HCFA). The former name of the Centers for Medicare and Medicaid Services (CMS).

3.3.42 Health Care Models.

3.3.42.1 Fee-for-Service (FFS) Models. A model that financially rewards providers based on the volume of services provided.

3.3.42.2 Value-Based Models. A model that financially rewards providers based on the value of the services they provide.

3.3.43 Health Maintenance Organization (HMO). An organized system of health care that provides or arranges for a range of basic and supplemental health care services to a voluntarily enrolled group of persons under a prepayment plan.

3.3.44 Incident Location. The address or other identifiable area of an event.

3.3.45 Incident Management System. A system that defines the roles and responsibilities to be assumed by responders and the standard operating procedures to be used in the management and direction of emergency incidents and other functions. [1561, 2014]

3.3.46 Incident or Onset Time. The time the incident occurred or the time that the symptoms developed.

3.3.47 In-Service Utilization Ratio. An efficiency ratio that divides the cumulative unit-elapsed intervals by the total time that a unit is on duty.

3.3.48 Interval.

3.3.48.1 Fractile Response Interval. A method of describing response intervals that uses frequency distribution as its basis for reporting.

3.3.48.2 Turnout Interval. The time from when units acknowledge notification of the emergency to the beginning point of response time.

3.3.49* Interview Ends. The time that the public safety answering point (PSAP) telecommunicator completes the interview with the caller.

3.3.50 Lead Agency. An organization assigned to organize the interagency oversight of the day-to-day conduct of policy related to a particular operation.

3.3.51 Life Support.

3.3.51.1* Advanced Cardiac Life Support (ACLS). A nationally recognized curriculum to teach advanced methods of treatment for cardiac, stroke, and other emergencies.

3.3.51.2 Advanced Life Support (ALS). Emergency medical treatment beyond basic life support level as defined by the medical authority having jurisdiction. [1500, 2018]

3.3.51.3 Basic Life Support (BLS). Emergency medical treatment at a level as defined by the medical authority having jurisdiction. [1500, 2018]

3.3.52 Management.

3.3.52.1 Critical Incident Stress Management (CISM). A program designed to reduce acute and chronic effects of stress related to job functions.

3.3.52.2 Total Quality Management (TQM). A management system fostering continuously improving performance at every level of function and focusing on customer satisfaction.

3.3.53 Medical Direction. The ordering of treatment, either through real-time communication or predetermined written protocols, by the appropriate medical command authority to approved clinical practitioners.

3.3.53.1 Off-Line (Indirect) Medical Direction. The medical direction that consists of predetermined standing orders, training, protocol development, and supervision that are authorized by the medical director.

3.3.53.2 On-Line (Direct) Medical Direction. The medical direction provided to out-of-hospital providers by the medical director or designee, generally in an emergency situation, either on-scene or by real-time communication.

3.3.54 Medical Director. A physician trained in emergency medicine, designated as a medical director for the local emergency medical services (EMS) agency.

3.3.55 Medical Oversight. The supervision, review, and administration of the medical aspects of an emergency medical services (EMS) system or agency and its providers.

3.3.56 Mobile Integrated Healthcare (MIH). The provision of health care using patient-centered, mobile resources in the out-of-hospital environment, including, but not limited to, services such as providing telephone advice to 911 callers instead of resource dispatch; providing community paramedicine care, chronic disease management, preventive care, or post-discharge follow-up visits; or transport or referral to a broad spectrum of appropriate care not limited to hospital emergency departments.

3.3.57 Multiple Casualty. Injury or death of more than one individual in an incident.

3.3.58 Mutual Aid. Reciprocal assistance by emergency services under a prearranged plan. [402, 2019]

3.3.59 National Association of EMS Physicians (NAEMSP). A national organization of emergency medical physicians and other professionals.

3.3.60 National EMS Information Systems (NEMSIS). The national repository that will be used to potentially store emergency medical services (EMS) data from every state in the nation.

3.3.61 National Highway Traffic Safety Administration (NHTSA). The agency under the United States Department of Transportation that is responsible for preventing motor vehicle injuries and deaths and provides national guidance on emergency medical services and systems.

3.3.62 National Institutes of Health (NIH). An agency of the Public Health Service of the Department of Health and Human Services, responsible for promoting the nation's health and providing medical research.

3.3.63 Non-Traditional Providers. Providers that may or may not be licensed/certified but who provide services necessary, such as social and health education, to meet patients' needs.

3.3.64 Outcome. The result, effects, or consequences of an emergency system encounter on the health status of the patient.

3.3.65 Patient Contact. The time that responding personnel first arrived at the patient's side.

3.3.66 Phone "Off-Hook" (answered in first PSAP). The time that the telephone is answered in the first public safety answering point (PSAP) center.

3.3.67 Protocol. Defines the prehospital care management of specific patient problems.

3.3.68 Public Safety Answering Point (PSAP). A facility in which 911 or other emergency calls are answered, either directly or through rerouting.

3.3.69 Quality Management (QM). The activities undertaken to establish confidence that the products or services available maintain the standard of excellence set for those products or services.

3.3.70 Response. The deployment of an emergency service resource to an incident. [901, 2016]

3.3.71 Response Resources Are Identified. The time that the public safety answering point (PSAP) telecommunicator, through computer-aided dispatch or other means, identifies the appropriate resources to send to the scene of the emergency.

3.3.72 Secondary Dispatch Phone "Off-Hook" Answered (if appropriate). The time that the second public safety answering point (PSAP) or second dispatcher answers the phone, begins the interview, collects caller data, and begins pre-arrival instructions.

3.3.73 Secondary Dispatch Phone Rings (if appropriate). The time the telephone begins to ring in the second public safety answering point (or the call screener).

3.3.74 Staffing. The number and level of training of personnel deployed on an emergency call.

3.3.75 Standard Operating Procedure. A written organizational directive that establishes or prescribes specific operational or administrative methods to be followed routinely for the performance of designated operations or actions. [1521, 2015]

3.3.76 Standing Orders. A direction or instruction for delivering patient care without on-line medical oversight backed by authority of the system medical director.

3.3.77 System.

3.3.77.1 EMS System. A comprehensive, coordinated arrangement of resources and functions that are organized to respond in a timely, staged manner to medical emergencies regardless of their cause.

3.3.77.2 Geographic Information System (GIS). A system of computer software, hardware, data, and personnel to describe information tied to a spatial location.

3.3.78 Telecommunicator. The individual tasked by a public safety answering point (PSAP) agency or communications center as the first of the first responders whose primary responsibility is to receive, process, transmit, and/or dispatch emergency and nonemergency calls for law enforcement, fire, emergency medical, and other public safety or public health services via telephone, radio, and other communication devices.

3.3.79 Time of Discovery of Event. The time that a third party or the patient becomes aware of the need for assistance.

3.3.80 Time of Result of First Intervention. The time that the responder first identifies results of the first intervention (e.g., when extrication was completed, when return of spontaneous circulation occurred).

3.3.81 Transfer of Care. The time that responsibility for treatment is transferred from a prehospital provider to another —

when the hospital personnel physically take over care of a patient.

3.3.82 Turnout Activation. Personnel preparation, boarding the vehicle, starting the vehicle, placing the vehicle in gear, and moving the vehicle toward the emergency scene.

3.3.83 Unit. A staffed and equipped emergency response vehicle.

3.3.84 Unit Acknowledgment. The time that the response unit(s) acknowledges that they have received the notification.

3.3.85 Unit Arrived on Scene. The time that the vehicle comes to a complete stop at the scene.

3.3.86 Unit en Route. The time that the vehicle first begins moving toward the scene.

3.3.87 Unit Left Scene. The time that the vehicle first begins moving from the scene.

Chapter 4 System Governance

4.1* General. This chapter outlines the core elements of an effective process for identifying, developing, and implementing community health care system governance. Governance ensures that community health care system components and oversight are comprehensive, clearly articulated and defined. Appropriate mechanisms should be instituted to ensure participation of system stakeholders in developing policies and regulations related to community health care programs.

4.2 Governance. In a similar fashion to other public safety and public health services, components of a community health care program may be regulated. Entities seeking to create community health care programs should assess existing governance.

4.2.1 Legislative Process.

4.2.1.1 In the absence of statutory oversight, the agency proposing community health care programs intending on engaging emergency medical services (EMS) or nontraditional providers, or both, should work with advocacy groups, labor unions, insurance companies, health care stakeholders, and other stakeholder groups to start the legislative process.

4.2.1.2* Health care stakeholders pursuing legislation to create community health care programs should consider mechanisms for receiving compensation from payers.

4.2.2 The authority having jurisdiction (AHJ) should determine the qualifications of the providers supporting the program.

4.2.2.1 Programs supported by EMS or other health care providers may require licensing/certification.

4.2.2.2 Programs supported by nontraditional providers may not require licensing/certification but may necessitate limited qualifications determined by the AHJ.

4.2.3 The AHJ should create a system that allows for the ability to create programs that meet local need(s).

4.2.4 The community health care program administration should demonstrate the need for community health care services for the populations served, including, but not limited to, community need(s), the level of service to be provided, a plan

for the operations of the program, and the mechanism to be used for evaluating quality based on the community needs assessment as addressed in Chapter 5.

4.2.5 The community health care program should identify the minimum roles, responsibilities, and education necessary to support a community health care program.

4.3 Local Governance. Program administration should be responsible for community health care program oversight and should be empowered to implement plans.

4.3.1* Planning. Program administration should design the program based on a systematic planning process.

4.3.1.1 Service Levels. Program administration should identify service types, levels, performance guidelines, and measures.

4.3.1.1.1 Program administration should consider factors consistent with local resources and needs, such as the following:

- (1) Health care system capacity
- (2) Reducing health care costs
- (3) Community expectations
- (4) Measurable patient outcomes
- (5) Resource availability
- (6) Financial capability

4.3.1.1.2 Program administration should use its data to identify specific needs that could be addressed with a community health care program.

4.3.1.1.3 Representatives of community health care user groups and EMS system stakeholders should be involved in designing expectations and developing policy.

4.3.1.1.4* Program administration should identify appropriate participants for program design and policy.

4.3.1.1.5 Program administration should have the authority to convene subject matter expertise to assist in designing and implementing policies, procedures, and operations.

4.3.1.2 Management Structure.

4.3.1.2.1 Program administration should have a defined management structure and clear lines of accountability. The existing management structure should be reevaluated periodically to ensure if appropriate supervisory resources are available.

4.3.1.2.2 Each position within the program should be defined according to its role and responsibilities.

4.3.2 Evaluation.

4.3.2.1 Program administration should ensure there is a quality management program as outlined in Chapter 8.

4.3.2.2 Program administration should develop processes, policies, and education that will enhance the components.

4.4 Patient Health Information Protection.

4.4.1 Program administration should ensure that appropriate policies and procedures are in place to protect patient and quality management records.

4.4.2 Program administration should have policies and procedures detailing how referrals will be received, processed, and distributed.

4.5 Provider Health and Wellness. Program administration should have policies and services in place to address provider health and wellness, including behavioral health.

4.6 Personnel Training Requirements.

4.6.1 Program administration should identify personnel to become community health care providers based on system needs, experience, interests, and their capabilities.

4.6.2 Program administration should prohibit the use of personnel who have not received the minimum training required by the organization.

Chapter 5 System and Community Needs Assessment

5.1* General. This chapter outlines a systematic approach for evaluating and analyzing a jurisdiction's existing emergency medical services (EMS) system as a means of adding a community health care program (CHP).

5.2 Community Analysis.

5.2.1 System Planning. The first step to establishing a CHP is an analysis of the existing system and its ability to meet local community needs. A collaborative approach should be established for assessing local needs and meeting those needs with specific service elements.

5.2.2 Evaluation of Existing System. Community needs and system components should be evaluated with specific attention paid to response data, patient care records, and other information, including, but not limited to, the following:

- (1) Local demographics and their implications on service requirements for a range of constituency groups
- (2) Age-related injuries and illnesses (e.g., pediatric, adolescent, or geriatric)
- (3) Socioeconomic and environmental structures and associated injuries and illnesses, both acute and chronic (e.g., poverty, violent crime rates, insufficient prenatal care, or neglect)
- (4) Gender-related injuries and illnesses, both acute and chronic (e.g., disease rates and treatment plans)
- (5) Language, cultural diversity, and ethno-specific disease processes

5.3 Historical Patient Data, Call History, and Demand. Authorities having jurisdiction (AHJs) should identify potential prevention and management targets by assessing historical patient data and call history and analyzing call types or patients that place a high demand on the system. This information will be helpful in ascertaining the initial target population to be managed through a CHP.

5.3.1 Distribution of Demand.

5.3.1.1 A geographic information system (GIS) may assist in identifying the distribution of calls in a community.

5.3.1.2 The distribution of demand should also be assessed by periods of the day, as well as months and seasons of the year, to determine the existence of any temporal trends.

5.3.2 Local Industry. AHJs should consider assessing areas of commerce and industry that may have a high occurrence of injuries and illnesses that have placed a demand on system resources (e.g., entertainment venues, exposure to hazardous materials, injuries from machinery).

5.3.3* Social Service and Health Care Facilities. AHJs should consider areas that offer social services, such as shelters (e.g., faith-based, municipal, or otherwise) that may place a demand on system resources.

5.3.4 Unique Local Geographical or Environmental Conditions and Demand. AHJs should consider possible limitations in accessibility (e.g., special hazards, geographic topography, land mass separations, waterway and marine boundaries) to the target population that could affect service delivery.

5.3.5 Public Health. AHJs should coordinate with their public health department as a resource for assessing the population for areas of concern that create a demand on the system and identifying possible gaps in access to health care and prevention.

5.3.6 Other Local Data Resources (as appropriate). AHJs should identify and assess other local data sources that can provide insight regarding demand on the system, gaps in access to health care and prevention services, or other injury and illness risks in the jurisdiction.

5.4 Comparable Organizations/Professionals.

5.4.1 Political/Regulatory Organizations. AHJs should assess the political and regulatory environments to identify organizations performing identical or similar work.

5.4.2 Other Health Care Professions or Professionals. It is possible that other organizations or health care providers are already performing complementary community health care work in the jurisdiction, and are doing so through legislative authority, past practice, or both. AHJs should assess the existing health care environment for opportunities to build relationships with these groups to fill gaps in the health care delivery system.

5.4.3 Legal Analysis. AHJs should perform a legal analysis to ascertain if the proposed program is supported by state, provincial, or federal laws, rules, and regulations.

5.4.4 Stakeholder Engagement.

5.4.4.1* Once a plan for a CHP program has been created, AHJs should invite internal and external stakeholders to introduce the proposed plan, and be open to receiving their input and fostering partnerships for service delivery.

5.4.4.2 AHJs should consider collaborating with resources that are external to the EMS system.

5.4.5 Lack of Regulatory Authority. AHJs that are operating in areas that lack regulatory authority that allow EMS providers to perform community health care work should partner with EMS, public health, and public safety advocacy organizations and labor associations to lobby for change.

5.5 Determination of Prevention and Management Targets. AHJs should identify vulnerable population groups or specific demand types that would benefit from prevention and management programs (e.g., age-related primary illness and injury prevention programs, chronic illness management programs).

5.5.1 Collaborative Process. AHJs should develop a collaborative process with public health and the local health care community to identify what vulnerable population groups or specific demand types would benefit from prevention and management programs.

5.5.2* Selection of Initial Target(s). Once populations of interest have been identified, the target groups should be ranked from highest to lowest based on the demand these targets place on the existing system. It should be noted that the initial target population may have mixed needs.

5.5.3 Prevention Efforts. Illness and injury prevention and education efforts should be linked to community needs and resource availability.

5.6 Establish Program Goals and Objectives. Program goals and objectives should determine service levels as a function of community needs identified through AHJ evaluation/analysis and community needs assessments.

5.7 Analysis of Internal System Resources.

5.7.1 Internal Resources. AHJs should analyze the existing internal resources available to serve the needs of the initial patient target(s), including financial resources, equipment and facilities, and personnel in the system.

5.7.2 External Resources. The program analysis should consider the resources and accessibility of all health care resources available to the AHJs.

5.7.3 Required System Resources. Based on the internal and external resource assessment, AHJs should determine the need for additional resources, including capital purchases, personnel, and partnerships, which may be necessary for operational success but are not currently part of the system or the system's inventory.

5.7.4 Value. The program should be able to articulate the value this CHP will generate for various stakeholders.

5.8 Program Design. The program design should be flexible and based on continual evaluation according to defined indicators and performance measures.

5.8.1 Service Levels. Service levels should be linked to community needs and expectations and be within the scope of practice.

5.8.2 Providers. The AHJ should identify the roles, responsibilities, staffing, and training requirements of providers for the CHP to achieve the desired outcomes.

5.8.3* Provider Resources. EMS systems are composed of the personnel, vehicles, equipment, and facilities used to deliver emergency and nonemergency care to individuals outside a hospital. Key services of an EMS system include public access through a coordinated communications system, public safety, public health, EMS response, and patient transportation.

5.8.4* Service Types and Descriptions. Each type of service within the program should be clearly defined and fully described in the program design.

5.8.4.1 Role Definition. Based on the needs and wants of the community, several different types and levels of providers may be required. Roles and responsibilities for each type and level of provider should be identified to ensure that the desired level of care is delivered continually and effectively.

5.8.4.2 Community Health Care Provider. The role of each community health care provider should be clearly defined by the AHJ.

5.8.4.3 Partner Agencies. The program should identify the roles and responsibilities of each partner agency needed for the program to function.

5.8.4.4 Structure. Providers may be supplied by a single organization or through the combined efforts of multiple organizations.

5.8.4.5* Telecommunicators. Telecommunicators may be the initial point of contact for patients who may benefit from the program. In addition to providing verification of the incident address, notification of the closest provider, and prearrival instructions, telecommunicators may be required to perform additional tasks.

5.9 Analysis of Program Barriers. EMS systems seeking to engage in a community health program should assess the external health care environment and identify regulatory barriers (e.g., laws, rules, and regulations prohibiting EMS from performing work outside of the emergency setting) and operational barriers (e.g., proposed system design that encroaches on other health care professionals' work).

5.10 Provider Support. The program should address and consider methods to support an individual provider's needs for addressing caregiver emotional concerns, such as compassion fatigue.

5.10.1 Provider Training. Providers should receive training on the local resources available to help meet the needs of patients enrolled in the CHP.

5.10.2 Provider Safety. The following should be in place to reduce the amount and severity of injuries incurred by providers:

- (1) Personal safety training
- (2) Equipment safety programs
- (3) Accountability/tracking/communications systems
- (4) Information applicable to location and physical or environmental conditions, including neighborhood safety programs

5.10.3 Wellness. Health and wellness programs should be in place to monitor and support the overall wellness of providers.

5.11 Finances.

5.11.1 Comprehensive Financial Analysis. The financial status of the community and its capacity to support the CHP should be evaluated.

5.11.2 Budget. Each entity should develop a financial plan that reflects sound analysis and planning of short- and long-term operating need.

5.12 Oversight.

5.12.1 Medical Oversight. Based on the community needs analysis, the program may require associate medical directors whose specialties are closely related to the needs of the target population. The CHP program may also use other medical advisors to help develop protocols for specific disease processes. Providers within the CHP may be authorized to consult with an enrolled patient's centered medical home for specific, individual medical care coordination and intervention.