Qualitative Evaluation of the Molina Community Paramedicine Program: Multistakeholder perspectives from members, significant others, and providers

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Table of Contents

Executive Summary

The Molina Community Paramedicine Program extends traditional paramedic care by having trained paramedics deliver a range of healthcare and social services to high-risk members in Molina Healthcare plan. A qualitative evaluation was conducted of the Molina Community Paramedicine Program to understand the experiences of participating members, significant others (SOs), and paramedic providers. Of 105 members who had participated in the Community Paramedicine Program in San Antonio, Texas, from 2022-2024, 21 members were interviewed. Although all participating members were asked to identify SOs to be interviewed, only 4 SOs were able to be interviewed. A focus group was also conducted with six paramedics serving the Community Paramedicine Program. All interviews and the focus group were audio-recorded and transcribed. Transcripts were qualitatively analyzed with a thematic analytic approach, triangulating the qualitative data from the three stakeholder groups: members, SOs, and paramedics. The qualitative analysis revealed several major themes about the Molina Community Paramedicine Program: 1) Paramedics visiting members regularly in their homes helped facilitate access and coordination to healthcare; 2) Paramedics provided important practical support and health education for members for preventive care; 3) Paramedics were valued and helped fulfill social and emotional needs of members; 4) Members sometimes experienced lapses in communication and scheduling in the program, possibly because paramedics had to manage multiple duties across programs and the program's lack of reliable vehicles. In conclusion, the Molina Community Paramedicine Program helped many high-risk members receive essential healthcare and supportive services, although there may be resource constraints to scaling the program.

Sharing Success Stories

Providers shared examples of patient progress—representing big shifts in health, stability, and independence. These stories highlight the impact of Molina's community paramedicine program on some members' lives.

From Frequent Hospitalizations to Stability

A young member with a frontal lobe brain injury had been cycling in and out of hospitals and struggling with behavioral issues, homelessness, and a lack of support. He couldn't manage Medicaid, medications, or appointments, and was turned away from most residential programs. Through the program, he received help with his care and found stable housing. His hospital visits have dropped to zero—and he's now living successfully in a personal care home.

Overcoming Anxiety, Finding Purpose

One member with severe anxiety and abdominal issues had gone to the hospital 12 times in 24 hours. Through regular coaching and building a strong personal connection, she learned to manage her anxiety and rarely returned to the hospital. She mentioned wanting to find a job. She was connected with a community partner —and months later, she was working there. She was excited, proud, and thriving.

A Simple Fix That Changed Everything

An older man in the program was missing appointments and becoming isolated due to poor vision and hearing. He had a hearing aid but had lost the charger and didn't know how to replace it. Within a few weeks, the program helped him get a new one. Once he could hear clearly again, his mood completely shifted—he was less frustrated, more engaged, and more hopeful. He has since had eye surgery and his quality of life has improved dramatically.

Background

There is growing interest in deployable, community-based healthcare programs that can improve access and care of adults who are frequent users of acute care services, such as emergency departments, homeless services, and inpatient hospitals.[1-3] One relatively new model of such programs that is receiving growing international interest is community paramedicine.[4] Community paramedicine extends traditional paramedic care by having trained paramedics also deliver a range of other healthcare and social services to communities, such as assisting with disease management, conducting home assessments, and making linkages to other community services.[5] These community paramedics can address non-medical drivers of health that are beyond the capacity and reach of traditional medicine models of care.[6] The role of a community paramedic is often a combination of four aspects: assessment, referral, education, and communication.[7] Paramedics who have downtime between emergency calls or are awaiting return to regular duties can provide these community services, leading to more effective use of paramedic resources.[8]

A 2019 systematic review found that community paramedicine programs are diverse and address a spectrum of population health and social needs.[9] But the review concluded there has been little empirical study of the impact of community paramedicine programs on the members served or the communities in which they operate. A 2022 systematic review, that included more recent studies, reported that there was evidence that community paramedicine programs can improve patient health outcomes, such as diabetes risk, blood pressure, and levels of care and personal health.[7] Improvements were also observed in the wider healthcare system where community paramedicine programs were operating, such as reductions in emergency calls, urgent care visits, and hospital admission rates. However, more careful study of community paramedicine programs is needed along with development of consistent training curriculum and integration with healthcare systems.[7] Notably, most existing studies have been quantitative, and there has been little qualitative study of paramedicine programs and their impact of participating members.

To address this knowledge gap, a qualitative study was conducted of a community paramedicine program funded by a large managed care organization in Texas. Three stakeholder groups were interviewed: the members served, identified significant others (SOs), and the paramedics who provided services. The goal of the study was to understand the experiences of people in the community paramedicine program and any impacts on their health and lives.

Methods

Program Description

Molina Healthcare started in 1980 and has grown into 19 health plans with 5.1 million members across the country by pioneering health care services exclusively for those with government-sponsored health care.[10] Molina Healthcare is one of the largest managed care organizations in Texas and began a mobile integrated health program in partnership with the Southwest Texas Regional Advisory Council (STRAC) to deploy a community paramedicine program in San Antonio.[11] This community paramedicine program is the focus of the current study. The Molina community paramedicine program involved local paramedic teams visiting and assisting local high-risk members covered by Molina Healthcare plans with health and social needs as well as helping members navigate needed resources. Eligibility for the program were Molina Healthcare members who had Medicaid, Medicare-Medicaid Plan (MMP), or marketplace health insurance; and had 5 or more emergency department and/or inpatient admissions within the past 6 months before enrollment. The stated purpose of the Molina community paramedicine program was to identify and address members' needs and barriers contributing to potentially preventable emergency department visits and hospital admissions. These needs and barriers included assistance with primary/specialty care; prescription refills; transportation; financial, housing, and food insecurity; untreated mental health issues or non-adherence with treatment; social isolation; and health literacy.

A research team at the University of Texas Health Science Center at Houston (UTHealth) School of Public Health served as independent evaluators of the program with funding support from the Episcopal Health Foundation and administrative support from Molina Healthcare.

Individual Qualitative Interviews

A semi-structured qualitative interview script was constructed with feedback from Molina Healthcare program administrators. The interview script consisted of various questions regarding the experiences and effects of the Molina community paramedicine program among multi stakeholders - members, their significant others (SOs), and paramedicine service providers. Members were asked how they became enrolled in the program, what the program offered them, their level of satisfaction, their perceived impact of the program, specific aspects that helped them, and suggestions they had to improve the program. Basic background information about members was also collected (e.g., demographics including age, race, ethnicity, and gender).

To recruit members to participate, Molina Healthcare provided a contact information list of all 105 members who had completed or were currently enrolled in the community paramedicine program in San Antonio, Texas, from 2022 to 2024. The list was sorted with a random number generator to randomize the order in which participants were contacted. Then, all members were contacted – at least 3 times by phone to invite them to participate in one-on-one virtual qualitative interviews. Of the 105 members initially contacted, 24 members had phone numbers that were out of service or were wrong numbers, and 15 members verbally declined participation. All members were told participation was completely voluntary, would be confidential, and would not affect their services in any way. Potential participants were provided a study summary and offered an opportunity to participate in virtual or in-person qualitative interviews. All participants opted to participate virtually. Prior to the interview, the interview team reviewed the study's informed consent, any questions with each participant, and obtained their verbal consent. The virtual interviews were conducted and recorded securely using UTHealth's Microsoft Teams. A total of 21 members were interviewed. Interviews lasted between 8 and 40 minutes; the average interview length was approximately 18 minutes.

After the interview, members were asked to identify a significant other (SO), which could be a family member, caregiver, friend who was knowledgeable about their experiences with the community paramedicine program so that they could be invited for a qualitative interview. Permission from members to interview these SOs was required before contacting them. These acquaintances/significant others were invited to participate in individual semi-structured interviews using a similar set of questions and procedures to collect information to supplement the members' interviews. Participation was voluntary. A total of 10 participating members identified SOs, and 4 SOs responded and consented to participate in a virtual qualitative interview.

Each interview was audio recorded and transcribed using Microsoft Teams' computer-assisted transcription service. The first draft of each transcript document was reviewed, revised, and translated to English – if necessary – for accuracy. To protect confidentiality, each transcript was de-identified by removing or replacing personally identifiable information such as names, locations, and other unique identifiers. Participants were assigned a three-digit ID number to protect anonymity.

Focus Group

Among community paramedicine service providers in the Molina program, an in-person focus group was held to collect information about the experiences of paramedicine service providers and their perspective on the program's impact on members, which members may benefit most from the program, and in what ways. Six service providers consented to participate in the focus group, were all involved in the community paramedicine program, and were all firefighters and paramedics for the San Antonio Fire Department. The focus group consisted of three sections including health/wellbeing, strengths and areas for growth/opportunities. For each section, members were provided a corresponding prompt and broken into teams of two. Teams were provided with a stack of post-it notes and invited to brainstorm a list of all corresponding ideas related to the prompt. These post-it notes were then shared with the focus group facilitators. One facilitator led a group discussion on the topic while the others grouped the post-it notes into meaningful categories. These categories were then presented on flip charts for the focus group to review. After further discussion, they were asked to place a dot next to the top three areas of importance/relevance. The focus group was held at the place of business of the paramedicine service providers in a private room. Focus group discussions were audio recorded and transcribed. The focus group lasted approximately 60 minutes.

Data Analysis

Transcripts of individual interviews with members and their SOs were analyzed using thematic analysis. Thematic analysis is a method for identifying, analyzing, and reporting patterns of meaning within data.[12] This method uses a structured step-approach to provide a comprehensive understanding of program participants' experiences.[13] Our team first reviewed the transcripts to familiarize themselves with the data and gain initial insights. Next, we conducted systematic coding, assigning descriptive labels to meaningful text segments. We used inductive coding, where codes and themes were derived from the data without predefined categories. These codes were then grouped into broader categories, reflecting patterns across our participants. Primary themes were developed from these categories to capture overarching insights from the data. Finally, themes were refined and validated collaboratively with the team, strengthening clarity and alignment with participant's narratives. These analyses were conducted in Atlas.ti (Version 25), a software program that facilitates coding, organization, and qualitative data analysis.

Transcripts and post-it notes from the focus group with providers were also analyzed with thematic analysis separately. While many of the themes aligned with those identified in the member data—highlighting shared perceptions of the program—the provider perspectives also offered unique insights into program implementation, care delivery, and system-level challenges. Given these distinct contributions, we report the focus group findings separately to highlight these views across our participant groups.

We used triangulation methods[14] to strengthen the credibility and depth of our qualitative findings by incorporating multiple data sources. This included 21 in-depth interviews with members, 4 interviews with their SOs, and one focus group with providers involved in the program. Triangulating across these perspectives allowed us to compare experiences, identify converging themes, and areas of separation. By integrating voices from members, SOs, and providers, we gained a more comprehensive understanding of the program's impact. Triangulation strengthens qualitative research by reducing bias that can result from relying on a single perspective and supports nuanced interpretations by capturing the complexity of multiple vantage points.[15]

Results

Member Characteristics

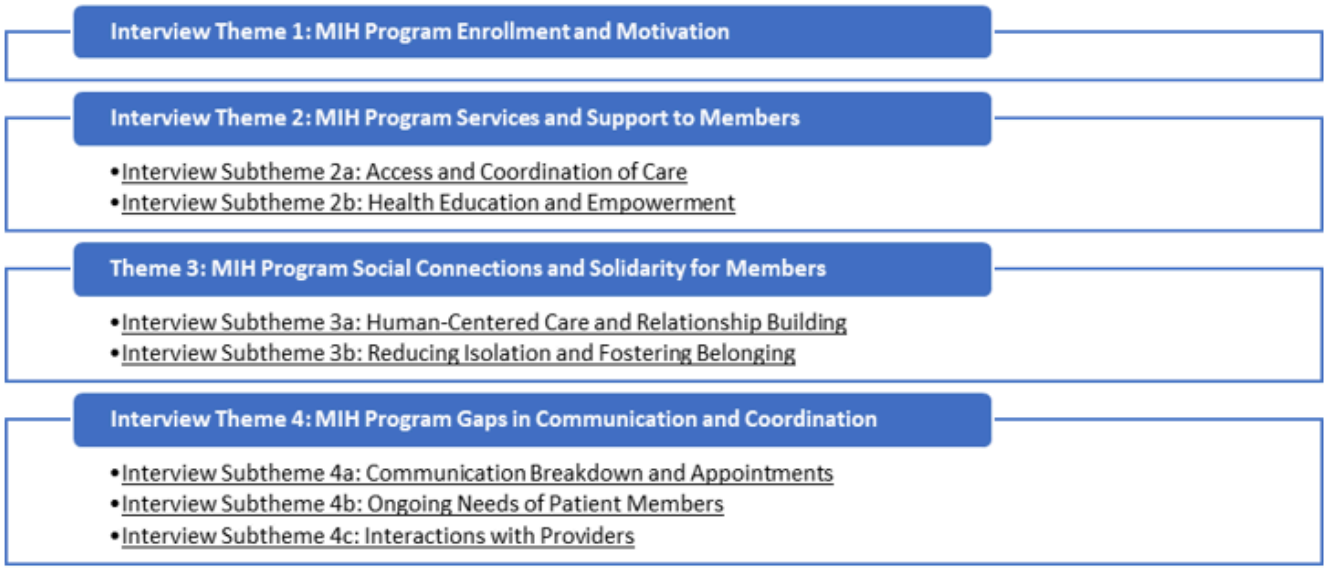
A total of 21 current (19%, N=4) or former members (81%, N=7) participated in the study (Table 1). All participating members were over the age of 40 and the majority were female and Hispanic/Latino.

Table 1. Background information of participating members (n= 21)

	n	%
Age		
40 – 44	3	14%
45 – 49	4	19%
50 – 54	4	19%
55 – 59	4	19%
60 – 64	2	10%
65 – 69	1	5%
70 – 74	2	10%
75 – 79	1	5%
Sex		
Female	15	71%
Male	6	29%
Race		
Black or African American	2	10%
White	5	24%
Unknown / Not Reported	14	67%
Ethnicity		
Hispanic or Latino	17	81%
Unknown / Not Reported	4	19%
Member Status		
Graduated	17	81%
Engaged	4	19%

Major Themes from Members and Significant Ones

From interviews with members and their SOs, we identified 4 primary themes related to the community paramedicine program: Enrollment and Motivation, Support and Services to Members, Social Connections and Solidarity for Members, and Gaps in Communication and Coordination.



Theme 1: Enrollment and Motivation

This theme explores the reasons and motivations behind members' enrollment in the program including frequent visits to Emergency Departments (ED), complex health issues, a desire to improve their health, and direct outreach, such as a "knock on the door." Members learned about the program through multiple channels including a card in their mailbox, a direct visit from the team, or indirectly by calling to inquire about additional health benefits.

> *A couple of years ago I was very, very sick, having, like having dizzy spells and a lot of things going on with my, you know, like, I don't know, I had a lot of things wrong with me. So, I will call the ambulance a lot and that's how I got in that program. (557)*

> *I got enrolled in it 'cause I was ending up at the hospital a lot. And I guess they thought that I wasn't taking care of myself, right? So, they enrolled me in the program. They enroll me in a program to make sure I stayed up with my health my appointments. (455)*

> *Well, when they first came to the door, I didn't know who they were. I was kind of confused on what was going on, but the guy they did come to the door was real helpful, gave me information. (717)*

Participating members were motivated to enroll when they had more information and learned about the available services such as transportation, in-home care, improving their health, and reducing their visits to the emergency department.

> *Well, just the fact that at that time anybody that's willing to listen or be concerned with your demise is pretty much of a godsend 'cause, you know, anytime you're alone, or you're broke, or you're old, people kind of really consider it the best option to stay away from you. (533)*

Member 779: Probably through the recommendation of Molina or something like that…This is what I think, it is a lot easier to be able to do tests and things like that in your home versus trying to find somebody, pay somebody or something like that. (779)

I believe I got a phone call from the fire department from the I guess the group around here that was participating. I always like to participate in the different things that are starting up or anything that has to do with my health and anything that can help me or help others. (641)

Frequent emergency department visits were an important reason members enrolled in the program. One participant described how the program provided support and an accessible alternative to the ED:

Because I go to the emergency room a lot that they were there to help try to prevent having to go to the emergency room quite so often. So, I felt like there was an answer for me if I couldn't get to my doctor's office instead of going to the emergency room. They were there to kind of intervene, they could help me instead of going straight to the emergency room. (641)

Other members explained that their frequent hospital visits and calls to 911 led to their enrollment in the program:

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For some members, the motivation to enroll in the program was not just about reducing ER visits but also about providing access to timely medical care.

To go to another doctor that will help us and be faster 'cause the one we're going to was taking forever and we were all day waiting. (856)

You have to go to a walk-in clinic and sometimes you're there for five hours to see somebody and who knows what you're going to catch in that time. So, it's difficult to get the care you need and then it's like is it worth it to go and sit somewhere? Or should I just wait it out. It's hard to get medical care right now. So sometimes it's better to have somebody come see you then to have to deal with going out. (641)

Enrollment in the program was driven by challenges in accessing timely care, frequent ER visits, and the need for better health management. Program members viewed it as an alternative to long wait times and hospital visits, providing proactive, accessible care. Beyond medical support, the program offered reassurance, critical intervention, and a pathway to more consistent healthcare engagement.

SOs also described being introduced to the program through outreach efforts, involving team members visiting their homes to explain the services and invite participation. SOs' experiences reinforced the importance of personal outreach in enrollment, helping families understand the program's purpose and potential benefits.

They explained it to her—what they could do to help a person, a patient like her, to get things moving.

The firefighters came over here and introduced themselves. When I saw them all outside, I said, 'Did we call them? Where's the fire?' And he goes, 'No, no, there's no fire.' He said he was with the fire department and with Molina, and they were going around the community because they were starting a new program that they were going to help people.

Being the fire department, I thought they did one thing—they go and rescue people from fires. But these are medical people as well, people who handle serious emergencies on the street or wherever. That's what I thought. So, it was really encouraging that they'll come to your home and check on somebody who's been sick. I thought that was very different—and encouraging.

Theme 2: Services and Support to Members

This theme captures the range of services provided to members to enhance access, coordination, and continuity of care. Subthemes around access and coordination of care, and health education and awareness were identified.

Access and Coordination of Care

Members described their experiences receiving access to responsive healthcare providers. The program facilitated connections with healthcare providers, ensuring access to medical services and supplies, and helping members navigate the healthcare system. This includes improving provider communication, ensuring continuity of care, and offering home-based and preventative support to promote long-term well-being.

For many members, the program played a vital role in accessing providers and medical care, particularly when they needed primary care doctors. A number of members described how the program helped them find a new doctor quickly when their previous doctor had left or they wanted to switch doctors.

> *Yeah. He helped me to find another primary care doctor that was quicker... 'cause the one we're going to was taking forever and we were all day waiting. Help finding a doctor and going with me to assist me to the first appointment. (856)*

The program also helped members receive essential medical equipment and resources, ranging from beds, blood pressure monitors, glucose meters and test strips, bedside commodes, bath chairs, walkers, canes, pull-ups, and medications.

> *They help me get my bed fast 'cause I was wanting a new bed, and they got it here as fast as they could, and I was always going to the doctor's office to buy my medication, so they picked up my medications at the pharmacy. They did a lot. (688)*

For members facing transportation barriers, access to medications, medical treatment and appointments were significant concerns. Members described the program addressed this by making sure prescriptions were picked up and delivered and providing transportation to treatment and blood work appointments.

> *I mean, there's times like if I get a migraine, I can't drive to go to the emergency room to get a shot. I always have to have a driver; they're not going to treat me unless I have a driver to take me home. And a lot of times you can't get on the bus and have a shot like that after a migraine, so I always have to find a driver before I can even go get treatment. And it's hard to rely on, you know, friends are at work, friends are busy... it's difficult for transportation. Once you start getting older, it's like there's so many things. It's like I hit 50 and it seems like everything went downhill. It's like everything happened. (641)*

> *He helped me to get a little machine. He helped me to get a new doctor. He even took me to get a ride over there to get some blood, yeah, to take out some blood that one time. (337)*

The program also helped participants access specialized health services and personal needs. One participant described how the program connected them with a pain specialist and provided financial assistance

> *Well, they help me find doctors. A pain doctor, that was like the main thing I needed 'cause I'm always in pain, so he helped me get into all that, and what else? Actually, I was behind in my rent too, he actually helped me with that too. (557)*

Members also described how the program helped facilitate interactions with providers, improving communication and enhancing care coordination for more streamlined and efficient patient support. For example, one member described receiving a lot of help from the program with navigating complex issues.

> *They would come, and they would take my blood pressure and check my blood. And they would ask me questions, you know, how I was feeling and all that. And they got to the point that I was having problems with my insurance. I couldn't get my hearing aids. So, my doctor retired, my primary doctor retired, so I had to go to another hospital and they're the ones that got in contact, they went over there. They got, I don't know, three or four doctors together, and they sat down with them, and they talked to them, and they told him what was wrong with me, and everything. They're the ones that got me that doctor that I have right now. I mean when I was having problems with the insurance, they tell me; would you give me your permission? I said, yes and they would be on the line with them, talking to whoever they were setting up appointments, or what they needed everything, I was giving them the okay to do it, but they did need to hear it from me. (717)*

Other members discussed the comprehensive support provided by the program that assisted patient-provider communication and their care coordination.

> *He would come to the house and ask what kind of stuff I needed because he said he would meet with the Molina person in charge and that they had a meeting. (411)*

> *Yeah, the doctor, my medications. We met up at my appointment before. He's talking to the doctors for me so I can get the medications that I needed. So yeah, he's done a lot. (557)*

SOs described the program as a critical bridge to timely medical care, particularly for members who struggled to access providers or navigate the healthcare system on their own. SOs shared that the paramedics often acted as translators, and helped advocate for members, which may have helped reduce emergency department visits.

> *The program seriously did their part—they were out there helping. In other words, they gave me a lot of information to help people avoid going to the emergency room as often.*

> *When things would happen to her, I would mention it to them—especially [paramedic's name]. He's the one who sped things up, because he would show up to the primary doctor and talk to them, telling them, "This is a necessity."*

SOs described their views on the program's role in helping families obtain essential medical equipment and resources for home use. These items—often difficult to access through traditional channels—greatly improved comfort, safety, and quality of life for members.

> *She had a lot of issues getting a bed, and he helped with that to move faster. They also got her a wheelchair and a manual chair.*

> *They helped with getting her equipment faster to avoid bedsores and with getting a lift.*

> *He needed the little machine— what do you call it—to check his blood, his sugars. He needed that and he needed some needle for the insulin, which he wasn't able to get, and they helped him with that. Now he keeps on getting them monthly, so it's really good they did all that. I was so happy they gave him everything that he needed.*

The program's in-home care and support provided healthcare and assistance services to members in their homes rather than in a clinic or hospital. These included regular vital sign checks (e.g., blood pressure, heart, and oxygen level monitoring), medication reviews, and ongoing assessments of members' well-being (e.g., screening for falls or new health concerns). Some members described these program services as critical to maintaining their health.

> *They would come, I believe, like once a month and they check my blood pressure and listen to my heart and take, I guess, my oxygen level and ask me questions as far as how I was doing, have I fallen, check stuff like that. Or, if there was anything that I needed, anything they could help with, do I need any community services that I need, you know, to help me find food or anything like that. Had I been to the emergency room or to the doctors, they asked if there was anything new, any new diagnosis or had I been sick or anything? So, they kind of kept track of my health and how I was doing. (641)*

> *"They always take my blood pressure and the review; what do they call it? When they get my medication and go through them one by one, which one I am taking and how much per day" (170)*

> *With my asthma and my immobility is just having the outside come to you … So, if I needed an X-ray instead of me having to find it right there, go sit in the lobby, be in pain in the lobby, being in pain having an X-ray, I got to do it in the comfort of my own home. I had people come and check my blood pressure. I had somebody help bring medicine to me. So whatever category you guys fit in, they fit in the best type of in-home services I had. (779)*

SOs had similar reports about the benefits of in-home care and assistance.

> *They came inside and started talking to [member], asking him what he needed, and he said, 'What I need is a shower.' So, they did that—they didn't take that long doing the shower. They were wonderful—the man in charge and his crew too. I think it was three weeks—they came, the people from Molina—they came and said they were gonna go ahead and start doing it, and I said, 'Wow, that was pretty good.' And they did the door, and he was really wonderful.*

They were very caring—you know, they're medical, right? They were asking her questions about how she felt, things like that, examining her—very pleasant and concerned, very careful with everything they were asking and doing.

SubtheremHealth Education and Empowerment

The program provided hands-on, in-home patient-centered health education tailored to each members' needs. This education included guidance on checking blood pressure, blood sugar levels, management of chronic health conditions, how to use Narcan to reverse opioid overdoses, and ways to access community resources.

I learned like how I needed to get my eyes checked and how to control my A1c. I mean, everything was learning 'cause I do I really didn't know too much. She explained to me what she was doing and then explained to me what I need to do, what needs to be done and how I can do it. And now I can get it done in two hours. (49)

The machine to check your sugar. I got that. I learned how I'm supposed to check it three times a day. I also got the thing to check my blood pressure, the little machine, and basically how to take care of myself better. (49)

They provided me with information. They gave me phone numbers; they gave me ways to get back and forth to if I needed to get to the doctor. He provided a list of things like he gave me a sheet with different things, as a matter of fact, it's hanging right here on my wall. He was like if you need anything else, let me know when I come out, I can get it for you. So, they were real helpful. (717)

SOs described the benefits of the health education provided by the team to not only the members but the SOs themselves as well.

They would take my mom's vitals. Every time he showed up, he would tell me, 'When her blood pressure is low, have her sit down for a bit—don't get her up.' A lot of things I didn't even know, and I'm my mom's caregiver and live with her, so it's really good for me to learn these things.

Theme 3: Social Connections and Solidarity for Members

This theme highlights the program's role in creating meaningful connections and emotional support for members beyond just healthcare services. The following subthemes were identified: Human-Centered Care and Relationship Building, and Reducing Isolation and Fostering Belonging.

Human-Centered Care and Relationship Building

Members described feeling valued as individuals rather than just patients due to the program's compassionate, patient-centered approach. The paramedics took the time to listen, engage in personal conversations, and show genuine interest beyond medical care. Many members highlighted how the team's attentiveness and kindness made them feel respected, cared for, and seen.

> *I'm very satisfied because they helped me out a lot they really did, and they were very caring and concerned about my situation and my health. (455)*

> *The quickness that you know they show how caring they were, how understanding, they never made me feel like a junkie, they never looked at me like, I don't know, it was just amazing I can't explain it (434)*

> *They just treat me like a human being, you know, they care. (674)*

> *The gentleman that I was assigned to was extremely nice. I mean, I never had to per say call them for any emergencies or anything like that, but he would come and because I have a lot of other things like, migraines or things like that to go to the emergency room with. I mean now I have some other issues that I'm dealing with but if I was feeling fine, he would just sit and chat with me, see how I was doing, which I know he didn't have to, but he would. He would just be friendly, and we talked about like the dogs and, you know, he tells me about his dogs, so, it wasn't all about medical stuff. He was just very friendly, and we talked about the dogs and cooking and plants and just, you know, things that I enjoy. So, he took an interest in me, not just let me take your temperature, your vitals, and I'm out of here, he truly took an interest in how I was doing. (641)*

> *Yeah, it was good wherever I asked for they helped me out with it. They were available with anything I needed help with, they did everything they could. There was impact there, they helped me not to give up, keep on going, moving, do more things, and more active a little bit. (855)*

Beyond medical care, the paramedics recognized the importance of emotional and mental well-being. One member shared a memorable experience that demonstrated a paramedic's thoughtful attention and care.

> *What I remember is that one of them saw that I like a lot of crafts, arts and crafts and stuff like that. On the next visit he got me some clay pots. He brought me the pots, so I could entertain myself, so I won't get that bored. (170)*

SOs also consistently described the program as one that treated their significant other as whole people and that the paramedics took time to learn about each member to reinforce a sense of dignity and emotional connection.

> *They helped him with anything that he needed in the world—they were staying on top of it. They were calling him, letting him know if he needed anything else. Anything that he needed, they were improving it and helping him.*

> *They were getting to know her, asking what she does, what she likes to do—as far as, like, how much she can do in terms of exercising, asking questions like that, even about her interests and everything. At one point, she said she had played the piano when she was little. They liked that, but pianos are expensive and hard to find. Still, they said, 'You know what? If we hear of something like that, we'll let you know so we can get you one.'*

<u>Reducing Isolation and Fostering Belonging</u>

The program played a significant role in combating loneliness and creating a sense of connection for members. Providers checked in regularly, provided emotional support, and even facilitated connections with other social organizations, like churches. Members expressed gratitude for these interactions, and appreciated knowing they were not alone:

> *I think it was mentioned to me very very frequently and maybe the three or four times that I talked or able to congregate was the fact that I wasn't alone and it's good to know … just the fact that you are talking to someone that you never met in your life and is concerned enough to go ahead and give you a call, in order to give some type of more support, it had value. (533)*

> *What do you do when you're going through stuff? I said I pray to God, he said, would you like for me to connect you with the church so you know they can come and see you or at least call you? And I said, oh my god, that would be amazing and he said okay, what's your religion and he said what church would you like, and he said okay, and they did contact me, I mean they're amazing, amazing there's nothing I would change they're doing an amazing job. (434)*

SOs also emphasized the value of the program in helping members feel socially connected.

> *They're attending to the patient's physical needs… all those things that a nurse usually comes and does. And then they're listening, taking the time to listen to them about different needs —not only physical, but emotional needs. So, they're taking the time to do all of that and encouraging them—if they're doing something good, or if they want to do something, encouraging them to do it, to follow through with it.*

Theme 4: Gaps in Communication and Coordination

This theme highlights challenges in communication and care coordination that affected members' experiences in the program. All members expressed valuing the program support they received, however, there were gaps in communication and unmet needs, and perceived unprofessional behavior that created uncertainty and frustration among members. Subthemes include Breakdown in Communication and Scheduling Appointments, and Ongoing Needs of Members.

<u>Communication Breakdown and Scheduling Appointments</u>
Some members experienced scheduling issues, inconsistent follow-up, and a lack of preparation for their end with the program. Miscommunication about visit schedules and follow-ups caused confusion and uncertainty for some members about when to expect their care visits or medical supplies. These issues also affected how they felt about themselves.

The biggest bad aspect for me was that they wouldn't come when they said they were and they didn't acknowledge their last visit, and it's like, okay, I don't know how to explain it, but I was really actually invisible to them…I mean, I know that I'm not the only client, but like grocery shopping and all that or reunions with family or whatever would have to be canceled just to get the help that I needed, you know from these people. And so, I would cancel my stuff because I did need the help myself. It kinda irritated me that they wouldn't do things the way they said they would." (194)

The people who are the coordinator, they don't coordinate nothing. I mean, I wouldn't be in the mess that I'm in right now, you know? And like, oh, yeah, well, we'll call you right back and we can set up a list of all the people that you can see. Yeah, they never call back. (411)

I think the only thing if I would say any negative about any programs that are dealing with people which is with people coming to your home is they kind of overlook the person's time like they'll call and say, hey, we're in your area. We'll be there in 15 minutes. That doesn't cut it. Just because I'm sick or I may be classified as a homebody or whatever, it doesn't mean that my time is any less valuable than anybody else's time. So, everybody was nice or whatever, but it is just felt ungenuine. (779)

Only one member reported a negative interaction with a paramedic they felt was "really rude and ugly" during a home visit. when they felt disrespected and judged during a home visit.

He looked upset when he knocked on the door and I opened the door, and I said would you like to come in or do I come outside? He said just come outside and the other guy was with him, and he looked at him like, Ok, and so, I sat outside, and I was trembling. I was shaking. I was sweating and I lit a cigarette, and he looked at me. He goes, can you put that out until we leave? And I was like, oh, wow, somebody's having a bad day. And then, he said, do you need our attention or not? He was really ugly. 'Cause, I told him he made me feel like a junkie, like trash." (434)

A few members described having only limited interactions with program services due lack of contact from paramedics, scheduling conflicts, or the members themselves having to be away from home. For example, one member described receiving mostly phone calls and often missing out because of conflicting schedules.

> *There were mainly phone calls and a couple of live visits, you know, basically a couple of times we coincided and then he probably made about four other attempts, but I wasn't here available. And then maybe about two, two or three phone calls. Really, just many phone calls and a few numbers phone numbers that he put in my mailbox in regards to who I needed to contact in order to expedite treatment or you know a few services, but basically, I mean nothing very extensive because I never really stopped with my life routine or my situation, so I wasn't like I was just sitting home too old or too weak, or too depressed to just wait for salvation, or a knock at my door." (533)*

Some members reported feeling unprepared for the transition out of the program and needed better guidance and continuity of care. This was also echoed by the SOs who expressed a desire for clearer communication about the end of the program, sharing confusion around why visits stopped and disappointment that the support was no longer available. One SO reported, "It was fairly often, but then it was stopped—I don't know why it stopped." Other SOs shared similar experiences of uncertainty, "Sometimes when they wouldn't show up, it was like, 'Okay, I guess they're not coming this week,' but they would show up the following week. If not, they would—like I said—the gentleman, he would do the calling. I wish it would have been longer, but I mean, we ended up getting all the stuff we needed."

Even when SOs understood the need to transition out of the program, they still felt the loss. Some wished for the program to continue in some form, even at the program's end.

I wish they would have kept on doing it, but like I said, I understand if they can't because of their job—what they're doing, attending to people who have emergencies, fires, and medical situations. So I feel a little guilty thinking, "Oh, they haven't come anymore," but they're so busy, so I understood that.

If possible, I thought it would be nice to have more visits once in a while according to the patient's needs, you know? Not every week, because I know they're super busy, but something like that.

Ongoing Needs of Members

Some members had reported ongoing needs that were not fully addressed by the program, such as having to wait on supplies and still experiencing financial issues. So the program was not a panacea for members.

No, I am good. But people me tell me to get out of the program, that program with Molina, that they don't help me. But I tell them, they do. But now that I'm paying a little for some medication, you know how sometimes there's money and sometimes there isn't. (252)

No, actually, I'm waiting because they didn't send me those things. Now I am buying them. It's already been like 4 months since they given me anything. Or the walker. I use the kid's stroller. It's because I fall to one side. I walk like the drunks. (252)

I still need help on my diabetes shoes and other stuff. I mean I still need more supplies for myself right now because have a hard time getting all that and getting to the diabetes doctor appointments once a while. (332)

Major Themes from the Provider Focus Group

Providers in the focus group included experienced paramedics and care team personnel who engage directly with members in home, community, and clinical settings. Tables 2-4 summarize notes of providers during brainstorm activities about program impacts on health and well-being, program strengths, and program areas for growth, respectively.

The top ranked impact of the program was on non-medical needs of members and linking members to benefits like insurance (Table 2). The top ranked program strengths were communication, trust, advocacy, and self-empowerment that the providers helped offer for members (Table 3). The top ranked areas of growth for the program were to have timelines and deadlines, and speeding up approval of resources to serve the members (Table 4).

Table 2. Health and well-being impacts ranked by each focus group member

Prompt: List "all of the ways the program has impacted your clients' health or wellbeing"		
Category	**Example**	**Importance Ranked**
Medication (compliance, filling medication)	*"Meds requested and filled"* *"Reminder to maintain medicine compliance"*	6
Primary Care	*"Help with PCP visits"* *"Provide medical care"*	5
Social Support	*"Identify support group (relatives)"* *"Social outlook/Enjoys Conversation"*	3
DME	*"Obtain DME" "Get DME fixed"*	2
Benefits Linkage	*"Navigating through insurance process"* *"Provide information regarding benefits with their insurance"*	1
Non-medical (transportation, housing, food)	*"Assisted with client getting housing"* *"Provide transportation"*	1
Equipment (e.g., hearing aids)	*"Provide durable medical equipment"* *"Able to get client hearing aids"*	-
Behavioral Health (Mental Health/Substance Use)	*"Received help with mental health issues"* *"Provide mental health care"*	-
Disease Management	*"Able to manage illness/disease"* *"Provide continuity of care"*	-
Urgent Care	*"Provide urgent care locations"*	-
Other	*"Identify needs"* *"Provide continuity of care"* *"Dental care"*	-

Table 3. Program strengths ranked by each focus group member

Prompt: List "the strengths of the program."		
Category	**Example**	**Importance Ranked**
Knowledge/Medical Experience	*"Knowledge base"* *"Medical experience"* *"Skilled, dedicated paramedics"*	5
Fire Department Uniform	*"Positive image"* *"Recognized as helpers"*	5
Doctors	*"Constant contact with Molina"*	5
Trust	*"Fire Department based program"* *"History of trust"*	1
Self-empowerment	*"Educating the patient"* *"Empowering the patient for self-care"* *"Individual progress"*	1
Communication	*"Good beside manners"* *"Good communication skills"* *"Great people skills"*	1
Community/Advocacy	*"Community partners"* *"Friendships"* *"Voice for the patient"* *"Medical professional advocating for patients"*	1
Financial Support	*"Financial support"*	-
Connections	*"Extensive contacts"* *"Working together with Molina case coordinators for solutions"*	-
ER Information		-

Table 4. Growth areas for the program ranked by each focus group member

Prompt: List "The areas for growth/weaknesses of the program."		
Category	**Example**	**Importance Ranked**
Staffing/Man Power	*"More staffing" "More manpower"*	6
Working Vehicles	*"Working vehicles"*	6
Funding	*"Model sometimes confines success"*	3
Resources/Insurance	*"Speed of approval of resources"*	2
Timeline	*"Timelines & deadlines"*	2
Denied Medications	*"Certain meds denied"*	-
Point of Contact	*"Better communication with care coordinators"*	-

These brainstorm activities fueled discussions in the focus group. Several major themes emerged from the focus group, including Support and Services, Providers' Social Connections and Solidarity for Members, and Operational Challenges and Opportunities.

Focus Group Theme 1. Support and Services to Members

This theme describes the paramedic's perspective of program support and services to members, which included helping advocate, navigate, and translating the needs of members to other healthcare providers.

The paramedics served as active advocates for their patients, helping them access medications, services, and essential supplies. They recognized that health outcomes are often tied to broader social conditions that they may be able to help with for long-term impacts on members. For example, one paramedic accompanied a member to court to help prevent an eviction—because housing stability is integral to the member's overall health and quality of life.

> *Last month, I went to court for a client because they were being evicted. He gets very frustrated when you talk to him, and it wasn't going to go well without support. I spoke on his behalf to the judge, who gave him a two-week extension, and then we got him into a new building.*

> *Primary care physicians do not know about their patients. Why? Because before the patient goes to the doctor's office, they clean up, they get dressed, they sit under control, they look their best. And the doctor says, "Okay, how are you feeling?" [and the patient says] "I feel great." It's like, "No, doctor, this is what's going on. This is what their house looks like. This is a picture of the house. This is how many times they've called 911. This is why they went to the hospital."*

Paramedics emphasized that advocacy includes bridging communication gaps between members and the healthcare system. The paramedics stepped in to facilitate these conversations, ensuring that members' needs were heard and addressed.

A lot of times, they don't talk to the primary care. They only have, like, twenty minutes per patient. That's where it's difficult, because a lot of these patients won't speak up for themselves—and that's what we do. It's like, "Alright, tell them why you're not taking these meds."

"So, this individual I've been working with, apparently, he was on hold with the clinic because he was having trouble connecting by phone due to the virtual setup. I assisted him by talking to the clinic, letting them know his issues—kind of transferring collateral over to them based on what his needs were. And as of today, I feel like I was able to empower him to follow through with his phone calls and take control over his care."

At time, the paramedics bridged communication gaps by translating clinical language to lay language for members, so they could better understand their treatments plans.

It's hard because they don't always understand what the doctor's telling them. I think that's the biggest disconnect—the level at which doctors speak isn't always clear enough for the average person to understand. And that's a huge gap."

Paramedics were able to offer real-time support to help members follow through with appointments and care plans—especially when logistical or motivational barriers got in the way.

I had a patient—I went into a doctor's appointment with her. The doctor said, "Alright, you need to get your labs drawn." We're walking out, and I was like, "Hey, where are you going?" She goes, "Well, my husband's waiting for me." And I'm like, "You've got to get your labs done." She hadn't done them in over a year. So, I had to redirect her and take her straight to get the lab draw.

Many times, we see this—a person who's dealing with substance use, and because this is their entry point to accessing care, they don't know how to navigate the process. We've had patients with Molina who were dealing with substance use, and we were trying to get them into a clinic or help them comply with appointments. This is where we come in and help navigate.

Program support included working closely with members to navigate insurance, medical providers, and the broader healthcare system to obtain necessary medications and ensure continuity of care.

> *I was dealing with this situation: "You need this medicine. Why aren't you getting it? Oh my gosh. You know you need it." And then— "Well, they didn't approve it." "Why didn't they approve it?" Then with Molina: "Tell them what the issue is." "Well, we haven't received it. This is what we need." Then I call the provider and say, "Hey, provider, this is what happened." "Well, we submitted it." Call Molina back: "Hey, they sent it, but we didn't get it. Can you resend it? Can you re-fax it? Can you do something?"*

The emergency medicine training of the paramedics shaped their approach to patient communication. "All of us have been paramedics for twenty years each before we came into this role." These years of experience shaped their translation of clinical recommendations and outcomes from unmanaged chronic conditions. "We see the end outcome when they don't take their metformin, or they don't take their insulin. In this role, you get to see things before the disease pathology takes over—and understand that if you don't do this, you're gonna end up over here."

Many paramedics understood member choices in the context of their socioeconomic backgrounds, and the common trade-offs faced by members: "It's like, 'I'm gonna buy an 18-pack of beer before I go ahead and buy my metformin." Paramedics used these insights to form their language and guidance to health communication. As one provider shared, "that understanding of the background kinda helped me because we know where they come from. In a sense, it's like—okay, this is what you're gonna need to do. Plus, they kinda like us because we're the fire department."

Focus Group Theme 2. Providers' Social Connections and Solidarity for Members

This theme captures the ways in which paramedics formed meaningful, personal connections with members—going beyond medical care to build relationships grounded in trust, presence, and mutual respect. Through consistent engagement and strong community identity, the paramedics became trusted figures helping members feel cared for and supported. The paramedics both had built-in trust as well as trust that they built over time.

A major strength of the program was the inherent trust the paramedics brough to interactions with members through their identity as firefighters. Members and SOs viewed them as credible, dependable, and approachable because of their uniforms, training in emergency medicine, and community presence. This built-in trust gave paramedics a unique advantage in engaging members—particularly those who might otherwise be hesitant to interact with healthcare professionals.

> *I think what makes our program successful is those decades and decades of trust that have been built, starting from the time people are this big. You know, everybody grows up understanding that the fire department is there to help you. So, when you show up in uniform, with the patch on, it's like—oh yeah, positive association.*
>
> *I really think the uniform is our biggest asset—no doubt in my mind. They see the connection with the fire department, the uniform of professional. And then when we go into the clinic, it's like, oh, we got an official here.*

The authority and trust associated with the fire department extended beyond members—it also enhanced communication and credibility within the healthcare system. Paramedics described how their presence and professionalism helped bridge gaps between providers and members to improve care coordination.

> *We do referrals that are written… in a professional manner with medical history, medication compliancy—everything that has to do with their chart. We show up in a professional manner coming from the fire department… That uniform goes a long way in our healthcare system.*

In addition to built-in trust, the paramedics also had to build trust with members over time. Through active listening, showing up in moments of crisis, following through on promises, and treating members with dignity, providers earned members' confidence. Trust was not always assumed—it was cultivated through steady, relational work. Paramedics described trust as foundational to engaging members meaningfully—especially those facing poverty, multiple medical issues, isolation, or inexperience with healthcare. Trust was built through consistency, empathy, and meeting members' needs.

As one paramedic shared, *"You're working with people who are at the lower end of the poverty level, and there's really no one out there helping them… They don't know what's available."*

Paramedics noted that members were often skeptical at first. *"We meet someone, and at first, they're like, 'Uh, okay... what do you want from me?'"* But when paramedics helped with practical needs—like food or shelter—trust began to form. *"If we can help them with just one of the top three things... we start to build trust."*

This approach shifted relationships from directive to collaborative. *"It becomes a give-and-take, instead of just us saying, 'We need you to do this, and this, and this.' It's a way to build trust."*

Once that trust was established, paramedics could begin shifting behaviors aligned with program goals, such as reducing avoidable emergency department use. One paramedic described this approach:

> *Then we say, "Let me give you this—but in return, I need your help with something." And they're usually open to it. Like, "Oh wow, you gave me this." And we say, "Yeah, now instead of going to the ER, can you call me if there's an issue? Maybe we can help you with something else." And they say, "Yeah, I could do that."*

Paramedics also described the power of "just showing up" in building trust with members. Offering routine medical services, supportive personalized care, and scheduling "check-ins" at the homes of members helped with health monitoring and social connection.

> *We show up with a monitor to take their vitals—and some of them haven't had that done in a long time. They get anxious because they don't know what their blood pressure is. We check it, it's okay, and it calms them back down. And we tell them, 'We'll be checking on you again next week.' They like that—just knowing someone's checking up on them."*

> *A lot of them were lonely, you know? And they looked forward to our visits. Just us showing up... they were grateful for any little help*

Focus Group Theme 3: Operational Challenges and Opportunities

This theme consists of structural and logistical challenges that impacted the day-to-day functioning and sustainability of the program. Paramedics identified key operational issues—including unreliable vehicles and limited staffing—as barriers to consistent care delivery. Subthemes include Vehicle Maintenance Challenges, and Program Staffing Opportunity for Growth. Despite these obstacles, providers expressed a strong commitment to the program and highlighted opportunities to enhance effectiveness, efficiency, and reach.

Vehicle Maintenance Challenges

One operational program challenge was access to reliable vehicles. Current vehicles used were older models—primarily 2017 and 2018—with high mileage. As these vehicles have aged, maintenance needs have increased, and breakdowns have become more frequent. *"They're breaking down, and they're over a hundred thousand miles."*

Under typical fire department protocols, vehicles are replaced after reaching certain mileage or age thresholds. However, for this program, no formal replacement plan currently exists. One provider explained: *"Normally, the fire department has a replacement rule... by 100,000 miles or over a certain age—and we've exceeded both."*

Unlike other units funded through grants or contracts that include vehicle provisions, this program does not have dedicated vehicle funding. *"Each program has funding for vehicles. Molina doesn't so we borrow vehicles."*

This lack of dedicated vehicles often required paramedics needing to borrowing from other units, which creates logistical complications and limits program efficiency. Moreover, navigating internal bureaucratic processes to request new vehicles could be slow. *"If you go through your bureaucracy, getting vehicles is a long deal. But if you go through a contractual vehicle, like with grant-funded programs, they get new vehicles."*

Program Staffing and Opportunity for Growth

Staffing was also identified as an operational challenge to the program. The current staff for the paramedicine program is small, limiting their ability to provide program services and support to many members. The program includes paramedics and support staff who are utilized across multiple programs, each with its own demands. This overlap makes it difficult to dedicate focused time and attention to the paramedicine program, despite the staff's commitment to the program's goals. As one participant explained:

> *We have at least 10 programs, and everyone here works across all of them. There are a few more folks who aren't here today, but this is pretty much everyone. And Molina is just one of those ten programs.*
>
> *Ideally, they'd like us to visit patients three times a week the first month, twice a week the next, and then once a week after that. But we can't always step away from our other duties to meet that schedule.*

Administrative support and flexibility from leadership were important factors in the program's ability to manage workload and meet program demands. The paramedics appreciated leadership's understanding of the program's complexity and the latitude to get the job done. *"And then there's the issue of timelines and deadlines. The more restrictions you put on the program, the harder it is to do the work. Thankfully, our administration gives us flexibility—they say, 'Go do what you do,' and we find a way to make it work."*

Participants noted that increasing staff capacity would significantly strengthen the program's ability to deliver consistent, patient-centered care for members. One provider put it simply, *"Definitely increase those numbers."* Another shared the perceived benefits of increasing the number of individuals staffing the program. They said, *"We'd be deadly even if you just had three guys and all they did was Molina—they'd kill it."*

They emphasized that frequent contact with members—while time-consuming—is also the heart of the program. When staffing allows, the model works well: *"When people are able to break away from their respective teams, and they have that time, it works. It's all step-by-step—it's just a lot of patient contact."* Despite these challenges, the paramedics remained committed to the work and to their members.

Conclusions

The qualitative themes discovered through this evaluation revealed that across members, SOs, and paramedics serving the program, the Molina Community Paramedicine Program is greatly valued and has helped many high-risk members receive the support they needed. Members of the program frequently expressed their appreciation of the paramedics and described the various positive impacts the program had on their physical and mental health, and the quality of lives. Taking together all the themes, the overarching findings can be summarized as follows: 1) Paramedics visiting members regularly in their homes helped facilitate access and coordination to healthcare; 2) Paramedics provided important practical support and health education for members for preventive care; 3) Paramedics were valued and helped fulfill social and emotional needs of members; 4) Members sometimes experienced lapses in communication and scheduling in the program due to resource constraints.

Despite the program's benefits to its members, the program was not a panacea for all of the members' needs and many continued to report ongoing needs after completing the program. In addition, there are several program areas for growth such as ensuring paramedics have access to reliable vehicles and adequate staffing that may need to be considered before the program can be expanded to serving larger numbers of members. Given the positive findings of the program and the willingness of the paramedics to serve the program, future expansion of the program may benefit other high-risk members.

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