A new paradigm for mobile healthcare emerged from a two-day meeting of EMS thought leaders held in Chicago in December. The group developed a framework to align the interests of patients, payors and providers as the first step in repositioning “community paramedicine” as one element in a more complex and comprehensive practice of medicine. The framework is intended to engage a wide spectrum of providers, including traditional EMS personnel as well as nurses, mid-level providers and physicians.

The group, which included representatives from private EMS, fire-based EMS, public utility EMS, third-service agencies, academic institutions, educational institutions and various national EMS organizations, was supported by an unrestricted educational grant from the Medtronic Foundation.

“The Medtronic Foundation recognizes the crucial role that frontline healthcare workers play worldwide in expanding access to care, including chronic disease care,” says Joan Mellor, program manager for the Medtronic Foundation. “We believe a project like this will lead to stronger community health systems that will ultimately improve patient outcomes.”

**SEEKING DEFINITION**

Although the concept of “community paramedicine” in North America is more than 20 years old, it has only recently gained momentum as the effects of healthcare reform have crystallized, such as penalties imposed on hospitals for patients who are readmitted within 30 days of discharge.¹ Many agencies are answering the call to integrate EMS into the complete spectrum of healthcare delivery (as outlined in EMS Agenda for the Future).²

Ironically, however, many such initiatives are moving away from the “emergency” aspect of EMS, toward more general medical services that address specific community needs, such as managing high-frequency system users, helping hospital partners reduce 30-day readmission rates and offering appropriate alternative destinations for complaints that do not require transport to a hospital emergency department.³

Interest in community paramedicine has now grown to buzzword status, with Google search engine results for the term topping 12,000 and more than 15,000 hits for the term “community paramedic” as of December 10, 2012. However, these Internet search results also show that there’s little consensus on what the terms actually mean. “Community paramedicine” is delivered and practiced in dozens of different ways.

These ambiguities and lack of common definitions has caused confusion and misunderstanding both within the EMS...
The lack of a standard taxonomy has meant that payors have been rightfully reluctant to reimburse providers for the care provided by EMS, a reluctance which now challenges the continued existence of many pilot programs. No common role definition, business model, competencies or metrics exist, and programs range from using on-duty paramedics in an alternative role without additional training to programs supported by college-level curricula, yielding practitioners who can bill for services provided.

Local, state and federal officials are beginning to explore the implications of a new provider role. Will this new role require expanded scopes of practice or simply an optimization of the current EMS provider role and skill set to better serve patients? This increasing dialogue is necessary and healthy, but it remains challenging to unify efforts and approaches at this early stage.

“This is an historic opportunity for EMS to take a prominent seat at the healthcare table,” says Ed Racht, M.D., chief medical officer of American Medical Response (AMR). “It’s critical for everyone involved in developing this new practice of medicine to work collaboratively and benefit from the substantial EMS and healthcare expertise around us.”

**Six Principles**

The group that met in Chicago developed six basic principles that address the patient experience, quality and cost issues for the EMS industry to consider as it moves forward with community paramedicine.

1. Identify the gaps in our current state of affairs.

“A unifying framework and taxonomy to define this practice and its relationship to healthcare at large has been notably missing,” says Eric Beck, M.D., medical director for the EMS system for the city of Chicago. “Community paramedicine has so many variations in practice that most people have only a vague concept of the term.”

Across the country, community paramedicine practice ranges from simple diabetic patient follow-up to full preventive medicine services, including the administration of vaccinations. Jeff Goodloe, M.D., medical director of the EMS System for Metropolitan Tulsa and Oklahoma City, adds, “I’m not even sure if ‘community paramedicine’ is the most appropriate term. Basic EMT providers could accomplish many of our goals, so I like to think of this concept more broadly as ‘mobile integrated healthcare practice.’”
EMR AT THE HEALTHCARE TABLE

[CONTINUED FROM PAGE 49]

2 Work together with all stakeholders.

“We’re all in this together. We’re not trying to compete with other facets of healthcare,” says Scott Bourn, M.D., AMR’s vice-president of clinical affairs and national director of clinical programs. “EMS aims to fill a need where other entities cannot. We really need to align the incentives of all stakeholders, which include payors, case managers, hospitals, legislators and industry—not just EMS agencies.”

3 Address common, or universal, program development matters.

“There are common issues that every program faces, which include the need for involved medical direction,” says Jeff Beeson, M.D., medical director of MedStar in Ft. Worth, Texas. The importance of local medical oversight cannot be overstated, as every community’s needs are defined by the unique patient population with very specific problems.

“Medical directors must be engaged with their crewmembers, local referring physicians, other local stakeholders and agency administrators from the beginning when forming these patient-centered programs,” Goodloe says. “We forgot to include medical oversight in the original 15 fundamental components of an EMS system, and we can’t make that mistake again when developing these types of programs.”

Many agencies are donating their services just to prove their program can work, but lack of reimbursement makes this model unsustainable. However, in return for funding, payors will demand to see quality, evidence-based patient care, demonstrated cost savings and patient satisfaction measurements. The healthcare reform movement has created a new level of accountability and transparency, and EMS will be a part of that.

4 Identify community-specific missions.

All medicine is practiced locally, and every community faces a unique set of challenges. Because every community will have different gaps in healthcare, programs should pay particular attention to those needs and problem areas.

“We should integrate principles of public health, such as various preventive medicine strategies, in our goals when putting community paramedicine programs together,” says Alan Craig, former deputy chief of Toronto EMS and now with AMR San Diego. “We should also ask patients what they want, rather than just telling them what they need. This will be a major driver of patient satisfaction indices.”

5 Identify all the unique components to this new approach to patient care.

The group defined each of the comprehensive components of a mobile integrated healthcare practice (see Table 1, below).

<table>
<thead>
<tr>
<th>Table 1. Mobile Integrated Healthcare Practice Core Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Medical direction</td>
</tr>
<tr>
<td>2. Coordinating communication</td>
</tr>
<tr>
<td>3. Integrated health care record (HIE/HPE)</td>
</tr>
<tr>
<td>4. Patient centered access</td>
</tr>
<tr>
<td>5. Telepresence/health/monitoring</td>
</tr>
<tr>
<td>6. Strategic partnerships</td>
</tr>
<tr>
<td>7. Capacity of navigation</td>
</tr>
<tr>
<td>8. Healthcare providers</td>
</tr>
<tr>
<td>9. Transportation</td>
</tr>
<tr>
<td>10. Sustainable funding</td>
</tr>
<tr>
<td>11. Performance measurement</td>
</tr>
<tr>
<td>12. Community assessment</td>
</tr>
</tbody>
</table>

6 Establish benchmarks and performance metrics.

“Programs may be tempted to simply demonstrate cost savings, but other benchmarks should include provider satisfaction in addition to patient satisfaction surrounding their care,” says J. Brent Myers, M.D., medical director of Wake County EMS in North Carolina.

Phil Moy, M.D., an EMS Fellow at the University of North Carolina at Chapel Hill, adds, “Some stakeholders may not even see cost savings as the end goal, but rather an overall improvement in patient care, patient satisfaction or staying off the penalty list of CMS.”

ENDLESS POSSIBILITIES

We already know that programs focused on high-risk populations can reduce hospital readmission, reduce costs and increase the interval between discharge and need for readmission to a hospital. Such programs have been administered by nurses, pharmacists and, now, paramedics. But EMS personnel are uniquely positioned within an existing infrastructure to interface with patients at every phase of their care, from point of injury or illness through convalescence.

“Our opportunities to enhance and improve the lives of the patients we serve are practically limitless,” Racht says. “We are perfectly poised to address specific gaps in healthcare needs along the entire spectrum. Not only that, but the opportunity to develop a new breed of EMS practitioner and expand career options is exciting. It’s a really historic time to practice EMS medicine.”

A critical focus of the Chicago meeting was developing the guiding principles of any new mobile integrated healthcare practice. Because each community is unique and every practice of medicine is designed to care for patients in a multidisciplinary way, the group felt it was important to establish guiding principles that supported the development of this unique practice of medicine.

Lynn White, AMR’s national director of resuscitation and accountable care, is coordinating this community paramedicine work group and will submit a manuscript for peer-review in the next few weeks.

And with it, the evolution of EMS will continue.

JEMS

David K. Tan, MD, FAAEM, is assistant professor and chief of EMS at Washington University School of Medicine in St. Louis. He also serves as medical director for AMR/Abbott EMS in St. Louis and was recently re-elected to the Board of Directors of the National Association of EMS Physicians.

REFERENCES

AD GOES HERE