

Finding a New Seat at the Healthcare Table

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Will the emerging concept of mobile integrated healthcare practice transform EMS?



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*Ed's Note: At EMS World Expo's **Mobile Integrated Healthcare Summit** (http://emsworldexpo.com/healthcare_summit.php), EMS executives and medical directors who are already making the transition to a mobile healthcare delivery model will come together to help agencies navigate this radical new environment. Attend this exclusive event on September 11, in Las Vegas, NV, free to conference attendees, to find out why mobile healthcare is more than just community paramedicine and will redefine your operations.*

In Reno, with the help of a \$9.8 million federal Innovation Grant, the Regional Emergency Medical Services Authority (REMSA) is partnering with local health and social service agencies to take intoxicated patients directly to detox and psych patients to a mental health facility. They're also finalizing plans to make house calls to recently discharged hospital patients with chronic illnesses to prevent readmissions. And they're working to establish a seven-digit nurse triage line as an alternative to 9-1-1.

In Fort Worth, MedStar Mobile Healthcare, formerly known as MedStar Emergency Medical Services, has arrangements with local hospitals, doctors' groups and hospice organizations to be paid to provide services to congestive heart failure and hospice patients at home, also with the goal of improving care while avoiding costly trips to the emergency department.

These efforts are part of a burgeoning movement that some of EMS's most influential leaders are calling mobile integrated healthcare practice. From telemedicine to prevention campaigns, from community paramedicine to nurse triage lines, mobile healthcare moves EMS industry definitively out of the realm of public safety and positions it firmly within the realm of healthcare.

"EMS needs to rethink its basic mission of being about transportation and instead be about providing care in the most effective way for the patient," says Eric Beck, DO, NREMT-P, medical director for the Chicago EMS System and the Chicago Fire Department, and a leader in the mobile healthcare movement. "That could be community paramedicine. It could be by integrating nurse triage into dispatch, or using telemedicine to enable patients to be treated at home without having to transport."

To its advocates, mobile healthcare is more than a tweaking of what EMS does, such as adding a new medication or procedure. Rather, it's a redefining of what EMS is, emphasizing measuring patient outcomes over processes like response times, and enabling paramedics and EMTs to take on a broader role in the healthcare system by filling gaps in services based on community need. While no one questions that EMS will continue to answer 9-1-1 calls, or that emergency medical response will remain a key part of the mission, true emergencies represent a small percentage of call volume and EMS's identity needs to be expanded to reflect that, mobile healthcare supporters say.

Not only does the shift add value to what EMTs, paramedics and EMS systems have to offer a community, but there's a compelling financial reason to do so. With the Centers for Medicare & Medicaid Services (CMS) and major insurers moving away from fee-for-service toward a pay-for-performance reimbursement, EMS has to find a way—and soon—to make sure it's not overly reliant on billing for transporting patients to the hospital, the most expensive place to receive care.

"For the last 27 years, we have been MedStar Emergency Medical Services. In January, we transitioned to MedStar Mobile Healthcare," says Matt Zavadsky, MedStar's public affairs director. "The fastest growing component of what we deliver does not involve ambulance transport to provide emergency medical services. More and more, what we are providing is mobile healthcare. The world is changing, and we have to change with it."

Healthcare Reform Driving Changes

Just how substantially is the world of healthcare changing? Over the past two decades, as healthcare costs soared and it became evident that the pace of the increase was unsustainable, a healthcare reform effort took root. New models of care emerged, including patient-centered medical homes and accountable care organizations, which seek to put an end to incentivizing physicians for providing more services, and instead dole out rewards and penalties based on outcomes—that is, how patients fared, and whether the care they received was cost-effective.

The goals of all reform efforts are summed up by what the Institute for Healthcare Improvement calls the “Triple Aim”: lowered costs, improved patient experience and improved outcomes.

The pace of change picked up with the passage of the Affordable Care Act, which includes both a carrot and a stick approach: large grant programs for healthcare providers that show they can achieve the Triple Aim, coupled with CMS fines for hospitals with excessive readmissions within a 30-day window. For hospitals, the stakes are high, says Ed Racht, MD, medical director for American Medical Response, the nation’s largest private ambulance service. Hospital chief medical officers have confided, he notes, that the 2% readmissions penalty is of less concern than what a high readmission rate does to their reputation.

Rankings are easily accessible on the Internet, he points out. “So if a hospital is one of the high readmitters, the community might perceive that if you go to that hospital, the chances of them not fixing you and getting readmitted is high, so why would you go there?” Racht says. “Insurers will look at that same list and say, *Wait a minute. Spending is higher on our patients there. Maybe we shouldn’t include them in our plan.*”

That certain people cost the system a lot of money, and that those people are often not best served in EDs, isn’t news to EMS. Every EMT and paramedic knows all too well the futility of transporting patients to the hospital when they really need a prescription filled, a check-up by a primary care physician, or mental health or social services. Likewise, EMS managers have been feeling the pinch of downward pressure on Medicaid and Medicare reimbursements as populations of the elderly, chronically ill, underinsured and uninsured have grown.

This turmoil prompted forward-thinking EMS leaders to look around and ask: How long would it be before pay-for-performance would reach EMS? How could EMS avoid becoming viewed as just another expense and instead become a part of the cost-containment solution? With its 24/7 mobile workforce, how could EMS do better at delivering an appropriate level care, where and when people need it?

“Those of us who have been in EMS long enough have always seen the potential of the EMS system—its operational structure and the people who provide it—to do more than respond to 9-1-1 calls or move patients from point A to point B,” Racht says. “For decades we’ve come across situations where we’ve said, *Gosh, this lady doesn’t need to go to the ED. But I can’t just leave her here. I wish there was a better way.* We felt the frustration with the current healthcare delivery system, and we saw the potential of the EMS structure to be a major contributor in helping to change how medicine is delivered.”

Community Paramedicine Gains Steam

For some, the solution was community paramedicine. Innovators like Gary Wingrove, founder of the International Roundtable on Community Paramedicine and the North Central EMS Institute, promoted the concept of paramedics with expanded training who could fulfill a variety of community health needs and led the development of a national community paramedicine curriculum.

Other pioneers included Chris Montera, who as chief of Western Eagle County Ambulance District in Colorado launched a program in cooperation with public health to have medics help with medication compliance, blood sugar monitoring and immunizations for children in Eagle County, an underserved, rural population. Then there are the advanced practice paramedics who serve in Wake County, NC, under the medical direction of Brent Myers, MD.

With measurement of results a key part of reform efforts, others in EMS focused on research and quality improvement initiatives to prove that EMS can impact patient outcomes. In 2009, the National EMS Advisory Council produced the seminal document “EMS Makes a Difference.” Other initiatives include AMR’s Caring for Maria, aimed at improving outcomes and patient experience in several key areas, including pain management, and the HeartRescue Project, a collaborative effort sponsored by Medtronic Philanthropy, the nonprofit arm of Medtronic Inc. Its goal is to improve sudden cardiac arrest survival by 50% within five years in six partner states and with AMR.

“With EMS, our traditional focus has been, *You call, we haul.* As a matter of fact, we’ve been reimbursed for ALS, BLS and mileage, not specific care we provide,” Racht says. “To make that cultural shift to accountable, performance-based care, we have to really, really focus on outcomes now. That doesn’t mean, *We get there in eight minutes, 59 seconds 90% of the time.* We have to prove that we make a difference, such as improving pain and improving physiological conditions, which is something that is relatively new for EMS.”

Last spring, community paramedicine got a big boost when CMS announced more than \$13 million in grants to launch community paramedicine programs in Pagosa Springs, CO, Prosser, WA, and Reno/Sparks, NV. In Reno, in addition to transporting mental health and intoxicated patients to alternative facilities, paramedics who have undergone four hours of additional training on conducting an advanced assessment can transport patients with low-acuity medical conditions such as a cold, cough, flu or minor laceration to one of four urgent care centers or clinics, says Brenda Staffan, REMSA project director. Under the grant, REMSA receives the same reimbursement for taking a patient to a non-ED facility as it would for an ED transport.

What’s In a Name?

Yet even as they lauded community paramedicine’s progress, some in EMS wondered if the term “community paramedic” or “advanced practice paramedic” was too restrictive to describe what EMS was in the process of becoming.

“In Chicago in the ’90s, there was a pilot program that sent EMT-Basics trained in the pediatric immunization schedule to housing projects. Those EMTs would identify the children, send them to a nurse who would get the child immunized and then connect them with a pediatrician for primary care follow-up,” Beck says. “What I like about this is it takes an EMT-Basic, who hasn’t gotten a lot of attention in the community paramedicine sphere, doing an important primary prevention task in a defined, underserved population. They immunized more than 1,000 children, and they teamed up with other providers to close the loop.” (The vaccine program ended when the projects were demolished.)

Participants in the HeartRescue Project, including Racht and Beck, in between sharing notes on resuscitation best practices, had been informally discussing how community paramedicine was creating new opportunities for EMS. In December 2012, a group of them got together for a more formal meeting in Chicago to discuss their experiences and ideas. Underwritten by Medtronic Philanthropy, the meeting included Beck; Myers; Jeffrey Beeson, MD, of MedStar; Joan Mellor, senior program manager for the HeartRescue Project; and four representatives from AMR, including Racht; Scott Bourn, vice president of clinical affairs; Lynn White, national director of resuscitation and accountable care; and Alan Craig, vice president of clinical strategies.

The concepts of community paramedicine and mobile healthcare are of particular interest to Medtronic Philanthropy, Mellor notes, because an important goal of the organization is to support the development of programs that expand access to care for the underserved with chronic diseases, measuring their success and replicating the programs elsewhere.

“If you empower patients and engage the frontline healthcare workers, you will help people living with chronic diseases to be more successful in managing their condition,” she says. “In the United States, a big part of the frontline is EMS.”

While the original intent of the meeting was to explore a more cohesive approach to community paramedicine, the conversation evolved into the broader concepts of mobile healthcare, Mellor reports.

One of the main questions that emerged was what to call this collection of ideas. While community paramedics would be important participants, not everyone had to be a community paramedic. Nor was some iteration of *prehospital* a good fit, since EMS would increasingly provide preventive or *post-hospital* care. What they were looking for were more inclusive words, ones that emphasized collaboration among health, mental health, social services and public safety disciplines, rather than identifying the concept solely with EMS. “We are talking about something larger than community paramedicine and larger than EMS,” Beck says. “This is about *How do we bring together all of the appropriate resources to have collective impact on a health need for a population?*”

Eventually, the group decided on mobile integrated healthcare practice. “We are of course *mobile*. We need to be *integrated* with every facet of the community—health, social services and the public safety community. We don’t always provide emergency services, but we always provide *healthcare*,” Zavadsky says. “And the term *practice* is important for two reasons: Everything we do is under the supervision or direction of a physician. This is their practice of medicine. And practice means we are learning as we go.”

Racht agrees that the name fits and notes that a year ago, AMR began using “practice” with its local operations. “*Practice* has been traditionally associated with medicine,” he says. “We believe that’s an important message for the community and helps them understand the role a little bit better.”

While most are supportive of the general concept of cooperation, integration and an expanded role for EMS, not everyone agrees with the name. It’s too soon to abandon community paramedicine as a way of describing an enhanced role for EMS in healthcare, says Sean Caffrey, EMS programs manager at the University of Colorado School of Medicine and a board member of the National EMS Management Association.

“In the case of the community paramedic movement, the terminology is only beginning to gain acceptance, especially outside of EMS,” Caffrey notes. “It would be unfortunate to have subgroups of our community developing new terms that may confuse the issue and distract from our unity of effort in this important and evolving area of EMS practice.”

And “mobile integrated healthcare practice” is overly broad, Caffrey adds. “The term could be reflective of any number of services provided by virtually anyone,” he says. “As such, it does little to differentiate that we are talking about what EMS providers in particular are doing to impact the health of local communities.”

However the name unfolds, Beck suggests that getting hung up on terminology will distract from the bigger goal, which is EMS working together with other professions to solve problems and promoting that role for EMS to potential healthcare partners, private insurers and the government to ensure EMS is paid for providing that service.

“No one owns this process,” he says. “It’s merely a discussion. An open, grassroots exploration of a concept.”

Moving Ahead

With “mobile integrated healthcare practice” the working moniker, the group held a second meeting in March in Minneapolis that involved more stakeholders, and representatives from a variety of organizations, including the federal Centers for Disease Control and Prevention, the National Registry of EMTs, the National Association of State EMS Officials (NASEMSO) and the National Association of EMS Physicians, as well as community paramedicine pioneers and other interested parties.

Out of the meetings emerged broad industry collaboration in support of the concept and cohesion around five guiding principles:

1. Assess community needs, remain value-focused and feature a competency and evidence-based practice that ensures continual education, 24-hour community access and ongoing performance improvement.
2. Ensure community partnership with active medical direction.
3. Deliver improved access to care and health equity for population served through 24-hour care availability.

4. Focus on patient-centered navigation and offer community-centered care by integrating existing infrastructure and resources, bringing care to patients through technology, communications and health information exchange.
5. Use evidence-based practice, incorporating multidisciplinary and inter-professional teams through which providers utilize full scope of practice.

The community needs assessment is one of the key elements of mobile healthcare, because it helps determine who is involved, which patients are included and what care is delivered, White says. "What we're trying to do with mobile integrated healthcare practice is to have people take a good look at the community's resources and match those resources with the community's needs," she says. "If you've got medics, great. But there could be others who could also provide that service. It's about building a network so the gaps aren't there."

Racht puts it another way. "One size doesn't fit all," he says. "But one cultural approach has to be applied to all."

Rural EMS in Crisis

Nowhere is a culture of collaboration needed more than in rural America, says Jim DeTienne, president of NASEMSO. As EMS director for Montana's Office of EMS and Trauma Systems, DeTienne has grown increasingly alarmed about the strain on his state's volunteers. "In the last two to three years, more and more of my time is spent with services that can't get staffed, can't get people trained or aren't able to fund [rural EMS]," DeTienne says. "In Montana, we have built a EMS system on the shoulders of volunteers. That system is just about broken."

Finding people willing and able to volunteer is increasingly difficult, yet the tax base is too small and the call volume is too low to support a paid service. Taking care of the chronically ill in rural areas is especially difficult, he says. Too often, volunteers need to leave their job to take a patient to the hospital and end up waiting around for hours to transport them back home, only to get called again a few days later for that same patient, he says.

Perhaps paradoxically, by emphasizing the other things EMTs and paramedics can do besides 9-1-1 response, DeTienne believes EMS may be in a better position to secure the funding and resources needed for emergency response readiness. A mobile healthcare approach could shore up rural services in several ways. One could be by contracting with an urban or suburban service to "borrow" a paramedic to work a few days a week responding to 9-1-1 calls and providing other community health services in the rural community, while volunteers could handle responses at night and on weekends. Another method would be working with rural and regional hospitals to have EMTs in rural areas do outreach and follow-up with patients to prevent readmissions, or via participation in telemedicine programs.

"In five to 10 years, we're going to have a totally different EMS system, particularly in the rural areas," DeTienne says. "Mobile integrated healthcare is so interesting because it represents a new idea about how to support a service in a rural area better than we have in the past, by integrating our rural providers into the healthcare system."

A Sense of Urgency

Transforming EMTs and paramedics into mobile healthcare providers will likely require some additional education and training to support the shift from a largely protocol- and assessment-driven profession to one that requires more "complex decision-making," Racht says.

That doesn't necessarily mean changing EMTs' or paramedics' scope of practice, but instead reapplying skills they're already licensed to perform to other purposes—managing chronic diseases, helping patients navigate the healthcare system, heading off emergencies through prevention campaigns and public education such as vaccination and elderly falls programs, and intervening with serial 911 users. "We consider it expanded role vs. an expanded scope," says Doug Hooten, MedStar's executive director. "Our position is that we make 112,000 house visits a year. We assess patients, take blood pressure and so on. Everything we do today in our community health programs we also do every day in our 911 system. It's a little different focus, but there isn't a real change in scope."

Whatever the outcome of the mobile healthcare discussions, EMS leaders agree that it's critical that the entire industry—fire-based, private, public and third service—comes together, quickly, to figure out EMS's place in the new healthcare world order. "There is not a huge window of opportunity," Hooten says. "It's not 10 years. If we don't do it, it's 18 months to two years before the hospitals engage in sending nurses out of the field to do this very practice."

As new partnerships are being formed, new models of care are becoming the norm. CMS announced in May that it's making available another \$1 billion in Innovation Grants to fund projects that test healthcare payment and delivery models to meet the Triple Aim. Other professions, from respiratory therapists to X-ray technicians, are competing to provide services in the out-of-hospital arena. "Everyone wants to be in this space, because the reimbursement dollars are shifting to it," Racht says.

Of any EMS agency in the nation, MedStar is the farthest along in transforming itself into a new type of practice. The number of patients treated using their alternative delivery strategy is growing. More hospitals and other healthcare providers are interested in participating. They're also fine-tuning payment arrangements to align MedStar's financial interests with those of their partners, enabling MedStar to share in both cost-savings and risk. For example, local hospitals estimate the average cost of each CHF admission at \$17,500. If MedStar can prevent that readmission by working with the patient to manage the disease, MedStar is proposing that it will receive about 20 percent of the savings. If they're unsuccessful at preventing the readmission, they don't receive that money.

"The hospitals and the payers under our current health financing environment are very motivated to meet the Triple Aim," Zavadsky says. "If no one brings to them a solution they haven't thought of like mobile integrated healthcare practice, we will once again as a profession be standing on the outside saying, *We could have done that.*"

At AMR, Racht says his company has no plans of letting that happen. He and his team are talking with everyone from fire departments to hospitals to insurance companies to work out what these new arrangements will look like. "From AMR's perspective, we think that the EMS profession has a new seat at the healthcare table," he says. "And we want to help manage those patients not just in the 911 arena, but where they need it most."

New Committee Will Connect Mobile Integrated and Community Paramedicine Groups

In May, the National Association of State EMS Officials (NASEMSO) formed a new committee to bring together leaders in the so-called mobile integrated healthcare practice movement with those from the community paramedicine movement. Called the Mobile Integrated Health–Community Paramedicine Committee, the group will meet via conference call every other month to share information and ideas.

"As individual programs and EMS systems are moving into these areas, state-level EMS offices need to be better informed about what's going on and what the best practices are so we do our due diligence in protecting the public, but not doing it in a way that creates barriers to the continued development and innovation that needs to happen," says NASEMSO President Jim DeTienne.

In another sign that community paramedicine and mobile healthcare advocates view their efforts as complementary, leaders of both are joining forces in applying for an Agency for Healthcare Research & Quality (AHRQ) grant to hold a summit covering both topics.

In 2012, NASEMSO and the North Central EMS Institute held the first national summit on community paramedicine in Atlanta with an AHRQ grant. Eric Beck, M.D., medical director for the City Chicago's EMS System and the Chicago Fire Department, and other mobile healthcare advocates have since been invited to join the group's Steering Committee on Community Paramedicine. The plan is to hold a series of smaller conferences to discuss specific elements of community paramedicine and mobile health, such as education needs, medical direction and reimbursement, and then apply for another AHRQ grant to hold a joint Mobile Health–Community Paramedicine Summit in 2014, DeTienne says.

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