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How to build a community paramedicine program

Research the needs of your community and partner with other health care agencies to shape a program around solving a shared goal

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By Cate Lecuyer, EMS1 Editor

WASHINGTON — If you build it, they won't necessarily come.

An increasing number of agencies are eager to adopt mobile integrated health care into their services, but simply saying, "I want one of those community paramedic programs" is not the road to creation. Nor is trying to replicate what your neighbors are doing, no matter how successful they are.

It is not, by design, a one-size-fits all endeavor, Dr. Jeffrey Goodloe, medical director for EMS system for Metropolitan Oklahoma City and Tulsa said during EMS Today's session New Perspectives and Next Steps: Translating Mobile Integrated Healthcare into Policy.

Rather than just going out and doing it, "we need to be very purposeful and really think about what we're trying to construct," he said.

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The first step is to consider questions on the front end about what the problem is in your community and what you're trying to achieve, and then shape the program to fit that.

"You have to let the needs assessment drive everything else," Goodloe said.

The triple aim

A successful program should aim to do three things: improve patient experience, improve patient outcomes and reduce costs.

Together, these make up the Triple Aim, a framework originally developed by the Institute for Healthcare Improvement.

"This isn't about EMS," said Scott Bourn, vice president of clinical practices and research for American Medical Response. "This is about community needs. For many of us in this practice, this will be very new."

Access to available resources is key, and the Mobile Integrated Healthcare Practice is in the process of putting together a resource manual, which will include tools like how to conduct a needs assessment, said Lynn White, national director of resuscitation and accountable care for American Medical Response.

It should become available in the next month or so, and will be posted on their website.

When it comes to identify needs, the success of mobile integrated health care in Fort Worth, Texas, is a good example. That program began in 2009 because the year before MedStar transported 21 patients to the emergency room more than 2,000 times.

"We had a problem," said MedStar Mobile Health Medical Director Jeff Beeson. "Our problem. If you don't have a problem, you don't need a program."

They developed a system to identify frequent fliers and implement individual care plans for those patients. This led to programs with Hospice, physicians, nurses and social workers.


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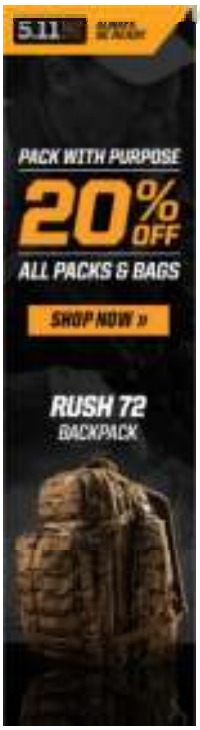

"Those programs weren't our ideas," Beeson said. "They were our partners' ideas. We became the go-to for our health care partners."

An inter-professional approach

In many cities, EMS is the ideal base to operate a mobile integrated health care system from, Goodloe said.

"But we don't have the competence alone to address all the needs."

The key to a successful program is being able to work collaboratively with a wide variety of health care workers to meet a common goal. All too often, paramedics and EMTs believe they have the skills to work together with others in the industry, but it goes deeper than daily communication with doctors, and requires additional education and training, said Eric Beck, associate chief medical officer at American Medical Response.

"Many people think they know, but they don't," he said.

For instance, a nurse who is doing dialysis on a patient at home may be very skilled medically, but isn't used to working in that environment. A medic, on the other hand, is comfortable in that setting and ideally the two could work together while playing to their strengths and teaching one another when it makes sense.

"It's a very different way of thinking compared to how we have traditionally put things together," Beck said.

While some regulations should be changed — like the California mandate that medics must transport patients to the emergency room — a multi-disciplinary approach will also eliminate many hurdles that responders may encounter alone, said Brent Myers, medical director of Wake County EMS.

"If you can't do something, partner with people who can," he said. "Use everyone at the top of their capacity."

Beck agreed that when delivering health care as a team, a solution-oriented approach to navigating regulatory constraints works best.

"Once you figure out what that need is, and who has a stake in it … you can go to them and figure out if they want to partner."

Recruiting changes

But at the end of the day, a community paramedicine program isn't for everyone.

"How many of you have employees who will say, 'I don't really want to do this?'" Bourn asked as many in the audience raised their hands.

The future of community paramedicine is closely tied to how the industry recruits, he said.

"We need to get people who are excited about it," he said.

Beeson was more direct.

"We need to quit going to high schools and showing pictures of car wrecks," he said. Roughly 70 percent of calls are not actual emergencies, and more often than not, EMS professionals find themselves visiting homes and holding peoples' hands. But it's difficult enough to providing training and education for what's already an established part of the job, never mind emerging health care trends.

"How," Beeson asked, "are we going to prepare the next generation?"

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