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Community Paramedicine for Fire-Based Systems

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CREATED: JULY 8, 2013

IAFF official discusses how fire-based systems can expand into community paramedicine.

Lori Moore-Merrell, DrPH, MPH, EMT-P

The American fire service has been outstanding at prevention—for evidence see the declining numbers of U.S. structure fires.

So an EMS future of mobile healthcare and community paramedicine aimed at preventing 9-1-1 calls and hospital readmissions shouldn't be conceptually alien to fire-based systems. In fact, many busy combined departments have already embraced a similar idea with targeted outreach to frequent callers, linking them to social services and other resources so they stop using 9-1-1 inappropriately.

Does that suit fire-based systems for expansion into CP? What else should they know, and what are their challenges?

At the **Firehouse Expo (http://firehouseexpo.com)** later this month (July 23–27) in Baltimore, the International Association of Fire Fighters' Lori Moore-Merrell will break it down for them. Moore-Merrell, DrPH, MPH, EMT-P, heads the IAFF's Division of Technical Assistance and Information Resources. She'll lead a workshop that covers the opportunities for fire-based systems in such expanded care, the legal and legislative landscape surrounding it, and the possibilities of things like treat-and-release and alternative transport destinations.

EMS World asked for a preview.

What will your Firehouse presentation cover?

Basically it will cover the community paramedic concept and how it will affect fire-based EMS systems. It's based on a paper we had our healthcare consultant prepare. It gets into ramifications for systems, what the opportunities are, what the long-term threats are, if any, what the new rules are going to be, those sorts of things.

The paper was written for us as a policy advisory. As of yet, the IAFF has not yet taken a position on community paramedics. We'll be sharing the paper with our standing EMS Committee in August during the **IAFF EMS Conference (http://www.iaff.org/Events/2013Redmond/index.htm)**, then the committee will use it to formulate recommendations to the executive board regarding policy.

Some busy fire-based systems have already reached out with interventions for frequent callers in an attempt to control call volume. Does this help prepare them for CP-style care?

Absolutely; I think we're already doing some of the things that would be contained here. The question is how those services that are already being provided will be formalized in new relationships with ACOs, or accountable care organizations.

The intent of the Affordable Care Act is that these conglomerates—the hospitals, the labs, all sorts of primary- and tertiary-care type facilities—come together to become all-services ACOs, with the intent to drive up quality, drive up competition and drive down costs. So as these things come together, what will be EMS' role? In both patient delivery into that system, and as patients come out the back end or are discharged and go home, what will be our role in caring for them to ensure they're not readmitted?

I think we're going to have a role in that, and I think it's going to be community-driven, based on need. The population itself is going to have some input. In Florida we may be providing different services than we would provide in, say, Ohio or California. The nature of those calls in each community will drive what services are provided.

A fire-based hospital follow-up program in Green Bay, WI, has the support of the chief, but the union is concerned about new duties being imposed unilaterally on its members. How will issues like that affect how fire-based systems proceed?

That is something we're hoping is going to be less common, but at this point the IAFF has not yet taken a position on it. Where our members have collective agreements that define their scope of work and where this would be a change in that scope, certainly it's their right to ask for some sort of collective bargaining over it—to have a talk about it before the department just puts it in.

However, it is going to be a chance for us to educate our members to these opportunities going forward, so they can make wise choices as they go to the table to talk about these new roles. We want them to consider all the possibilities and consider the future as they consider the changes coming down because of the ACA. We want them to be informed as they have these discussions.

On the EMS World Facebook page (https://www.facebook.com/EMSWorldFans), some commenters to that story referred to the program as 'babysitting' and 'taking us away from actual emergencies.' How do we overcome that mind-set?

I think that's going to require an education piece. In talking about 'true emergencies,' the key point is that they're one and the same! If we can take care of these people when they come out of the hospitals, we stop them from becoming those true emergencies again. That's a paradigm shift and understanding our people are going to have to come to as they learn more about this.

The truth of the matter is, someone's going to be delivering these services. It can either be the current EMS providers, or it's going to be someone else who's contracted, because someone is going to be delivering these services. Will it ultimately take people out of the 9-1-1 emergency call volume queue? Absolutely it will. A large part of that volume today is patients who are released and then become ill because they don't take their medicines or don't take care of their surgical wounds when they get home. These patients are one and the same.

What are some good examples of current fire-based community paramedic-type programs?

Around the Phoenix metropolitan area, they're moving forward very quickly to formulate agreements with some of the hospitals. That's probably about 26 fire departments coming together there to look at what they can do to stay in the loop and meet their communities' needs. There's another based in Kent, Wash., FD Cares, where they're working more on the front end for prevention. The leaders of both of those programs will be presenting at the IAFF EMS conference in August.

As fire-based systems move forward with efforts like this, are there cautions or lessons they should keep in mind, or best practices to embrace?

Here's one of the big things: I hate to use the term, but we come in with kind of a bargaining chip. What Medicare pays to EMS today for the patients we transport is probably less than 1% [of its total reimbursement spending]. But EMS controls a third of the access into the ACOs and hospitals today. Well, if we control a third of the patients and where they go—which may be a different facility than the local emergency room—then I think that's going to change. I think there's going to be some real interest from the heads of these ACOs and hospitals to talk to us about our role in delivering patients to them, rather than to their competition.

Is there anything else folks in fire-based systems should know about community paramedicine and these emerging care models moving forward?

I would just summarize by saying that a large contingent of fire departments in this country provide EMS at many levels, whether it's first response or BLS or an ALS transport where we do it all. We are universally an all-hazards responder. So that being said, this change in the healthcare law is going to drive some new opportunities, and it's going to help us highlight differently the needs in the communities we serve. I think fire-based EMS is going to step up to meet the needs of our communities as we always have.

Moore-Merrell's Firehouse Expo presentation will be held Friday, July 26, at 12 p.m. EDT. For more see ***http://firehouseexpo.com (http://firehouseexpo.com/)****.*