EMS 3.0:
Realizing the Value of EMS in Our Nation's Health Transformation

A draft joint position paper and proposed system development process by the :

- National Association of State EMS Officials
- National Association of EMTs
- National Association of EMS Physicians
- National EMS Management Association
- National Association of EMS Educators

“Nomenclature Incubator”
To
“Transformation Incubator”

(And a Process to Advance the EMS System and its Services)

Our nation's health care system is in the process of transforming from a fee-for-service delivery model to a patient-centered, and value and outcomes-based model.

Emergency Medical Services (EMS) is uniquely positioned to support this transformation and help achieve the Institute of Healthcare Improvement's (IHI) Triple Aim of:

- improving the patient experience of care, including quality and satisfaction,
- improving the health of populations, and
- reducing the per capita cost of health care.

To realize the potential value of EMS in this new health care environment, EMS must undergo its own transformation into a new version of EMS:
"EMS 3.0"

Expressed in the "service lines"
And "value"
Of EMS

Goal: To Define EMS 3.0 and to Help Services Advance From 2.0 to 3.0

History

Pre-1970 (“EMS 1.0”):

- Service line: transportation
- Value: fast response and transport

Post-1970 (“EMS 2.0”):

- Service line: transportation + care
- Value: fast response and transport
- Value: quality of care; life-saving

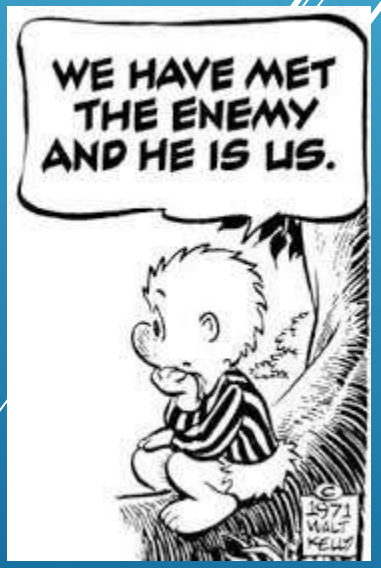
History

1972-1982 (Almost 1.0 → 3.0)

EMS system of care should extend from:

- *primary prevention* (to prevent injuries and emergency illnesses from occurring), to
- *secondary prevention* (to respond rapidly to emergencies when primary prevention fails and mitigate the impact of the evolving condition), to
- *tertiary prevention* (to provide care to prevent the reoccurrence of the injury or emergency illness).

But…..



Not Yet Ready for 3.0

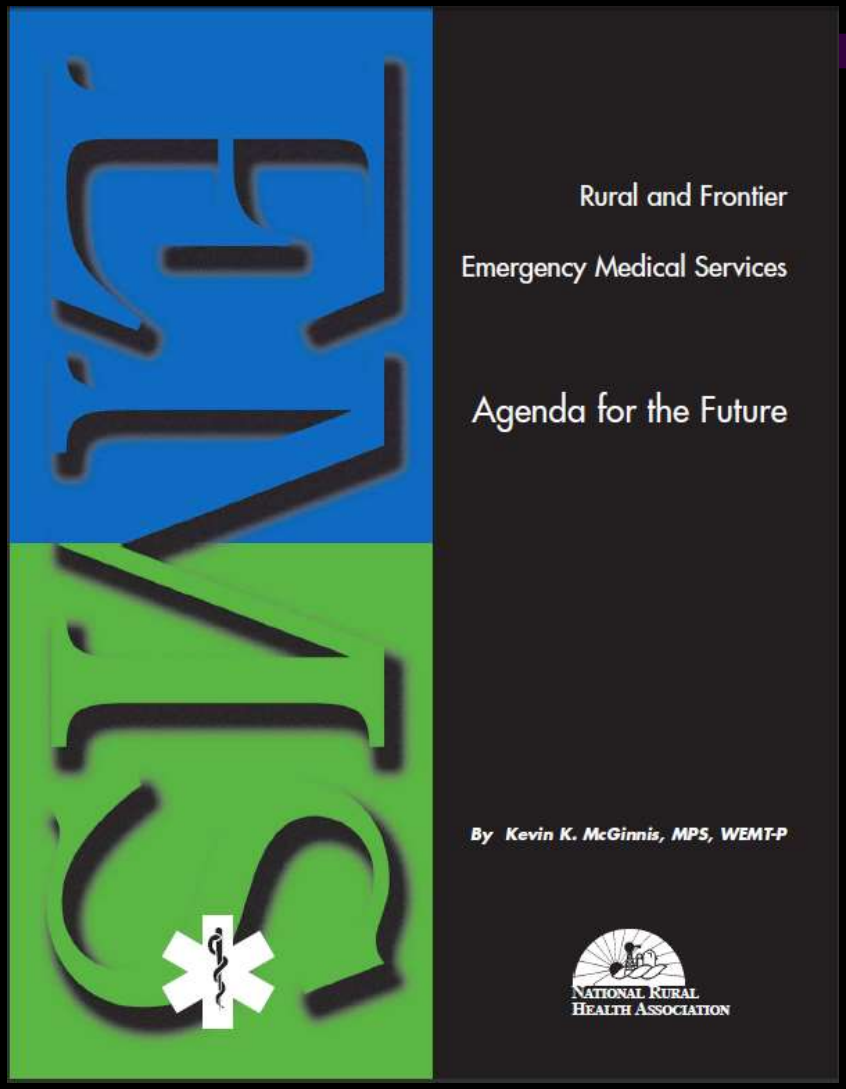
EMS Agenda for the Future (1996)
New Service Line and Value Concepts

*Emergency medical services (**EMS**) of the **future:***

- *Community-based health management …*
- *Fully integrated with the overall health care system…*
- *Able to identify and modify illness and injury risks..*
- *Able to provide acute illness and injury care and follow-up, and …*
- *Able to contribute to treatment of chronic conditions and community health monitoring…*

Not Yet Ready for 3.0

New Service Line: CP



The vision

The rural/frontier emergency medical service (EMS) system of the future will assure a rapid response with basic and advanced levels of care as appropriate to each emergency, and will serve as a formal community resource for prevention, evaluation, care, triage, referral and advice. Its foundation will be a dynamic mix of volunteer and paid professionals at all levels, for and determined by its community.

Almost Ready for 3.0……

The Ready for EMS 3.0 Value Proposition:

To remain relevant and valued in this new healthcare paradigm, EMS agencies need to offer service lines including:

- an integrated menu of emergency and preventative services
- that meet the particular needs of their communities.

Even agencies that are confident in their local tax-based support may not be able to focus solely on emergency response if they cannot demonstrate value.

The EMS 3.0 service lines include:

- Emergency medical dispatch (including provision of, or affiliation with, advice lines for patient navigation).
- Rapid response to emergencies.
- Emergency and critical care (ground and airmedical) transport.
- Interfacility and other medical transportation.
- Emergency medical assessment and intervention (basic and advanced life support for all age groups, tactical and wilderness emergency care, disaster preparedness and mass casualty medical intervention).

The EMS 3.0 service lines include:

- Logistical, operational, or clinical support of mobile integrated healthcare services operated by the EMS agency or by another agency, facility or system.

- Community paramedicine services, which may be part of an MIH system or operate as a stand-alone, can include some or all of the following:
  - urgent medical intervention,
  - preventive medical evaluation and care,
  - chronic disease assessment and management support,
  - post-discharge follow-up evaluation and management support, and/or
  - based on the assessments described above, patient transport, arranged transportation, or referral to other community health and social service resources.

EMS 3.0 provides essential value to the transforming health care system because:

- EMS is available in virtually every community.
- EMS is fully mobile and able to address patient needs 24 hours a day, seven days a week, and 365 days a year.
- EMS is an expected, respected, and welcomed source of medical assessment and care in people's homes and elsewhere in the community.
- EMS provides highly reliable patient assessment and intervention during calls to 9-1-1 and in response to emergency, urgent or unscheduled episodes of illness or injury.

EMS 3.0 provides essential value to the transforming health care system because:

- EMS is the provision of out-of-hospital healthcare under the medical direction and oversight of specialized physicians with unique knowledge of the delivery of healthcare in the out-of-hospital environment. Emergency medical services medical directors frequently coordinate with physicians of other specialties to enhance patient care.

- EMS, through its multiple service lines, can effectively navigate patients needing urgent or unscheduled care through the health care system to ensure they receive the right care, in the right place, at the right time.

EMS 3.0 provides essential value to the transforming health care system because:

- Community paramedicine services are able to fill gaps in patient care identified by its providers and by others in the community's health care network. EMS can prevent new or recurrent medical episodes through these services. This reduces the incidence of ambulance transports, emergency department visits, hospital admissions and readmissions, preserving medical resources and reducing costs.

- Mobile integrated healthcare is a model in which a variety of community health care providers/agencies organize to deliver a broad spectrum of patient-centered preventive, primary, specialty, and/or rehabilitative care outside of medical facilities. EMS can support this model by operating an MIH system or by providing CP services for it.

How Does "Community Paramedicine" Differ from "Mobile Integrated Healthcare"?

Community paramedicine and mobile integrated healthcare are both patient-centered, mobile services offered outside of medical facilities.

CP is an extension of EMS paramedicine practice and services to cover health care gaps in communities.

MIH is an administrative organization of multi-disciplinary medical, nursing, and other practices which may or may not involve EMS paramedicine providers.

Community Paramedicine

EMS 3.0 continues to operate in a system defined by state EMS law that is coordinated and regulated by a state EMS office. Those agencies and personnel who provide EMS' *lines of service* are licensed by that state EMS office.

Community paramedicine is provided as a *service line* by these agencies and personnel.

EMS 3.0 agencies may have contracts or other agreements to coordinate/integrate their CP services with other health/medical agencies, facilities, payers, and systems.

Community Paramedicine

EMS personnel typically receive additional education to deliver some CP services. “Community paramedics”, “community paramedic technicians”, “community paramedic clinicians”, “community paramedic practitioners”, “community health paramedics”, “integrated health paramedics”, and certain other designations describe personnel with more extensive, usually college-sponsored, specialty education to provide CP services.

These are specialty designations and not additional licensing levels of EMS personnel.

In some states, non-EMS health care providers may be certified as community paramedics (or a similar title) and therefore be providers within a CP service. Some CP personnel may operate in MIH, home health, and other agencies as well.

Community Paramedicine

When other personnel operate as part of the community paramedicine service, they are in the control of the EMS agency under the coordination and regulation of the state EMS office.

Others may operate in EMS 3.0 CP services in the same way the flight nurses and others operate in EMS agencies.

Mobile Integrated Healthcare

This is a multi-disciplinary, administrative organization of mobile health services which is operated by a health/medical agency, facility, or system.

An EMS 3.0 service may operate an MIH. This will usually be separate from the operations for which the state EMS office licenses it, because the MIH is an administrative construct of multidisciplinary independent practices over which the EMS office has no authority.

An MIH system's providers may include doctors, nurses, therapists, dentists, nurse practitioners, physician assistants, dental assistants and others.

How EMS Agencies Can Demonstrate Value to Health Care Providers/Agencies and Payers

- Recruit individuals to the EMS organization who understand and embrace the EMS 3.0 value proposition.
- Strengthen the competence of all practitioners within the EMS agency to ensure that it is ready to effectively provide the services that its community needs.
- Embrace continuous quality improvement and strive to adopt “pay for performance/value based purchasing” reimbursement/system funding linked to clinical outcomes.
- Capitalize on all opportunities to discuss how EMS 3.0 supports the health care transformation.
- Clearly articulate the types of services that EMS 3.0 can offer to improve patient outcomes and lower costs.

How EMS Agencies Can Demonstrate Value to Health Care Providers/Agencies and Payers

- Advocate for and support college-based education for EMS.
- Assess the potential for a CP program to benefit the community by addressing health care gaps. Assess the potential for that CP program to aid an MIH or other integrated healthcare system.
- If the EMS agency does undertake a CP or MIH service line, use appropriate tools to measure its effectiveness in improving patient outcomes and lowering costs.
- Integrate all of the agency's service lines into a well-coordinated, physician directed and performance-measured EMS 3.0 package of paramedicine services provided by practitioners at the basic and advanced.

Is this just integrating CP-MIH?

What is the process for Associations that sign on to EMS 3.0 development?

How will this integrate with NHTSA's desire to update the 1996 Agenda for the Future?

CP HAPPENINGS/RESOURCES

- Joint Committee on Rural Emergency Care
  (2nd Monday; 3 PM Eastern)

- Community Paramedicine Insights Forum
  (3rd Monday; 3 PM Eastern; CPIF.CommunityParamedic.org

- International Roundtable on Community Paramedicine
  (3rd Monday; 5 PM Eastern) www.IRCP.info

- NASEMSO CP-MIH Committee
  (4th Monday; 3PM Eastern)

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QUESTIONS?

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