EMERGENCY NURSES ASSOCIATION
SAFE PRACTICE, SAFE CARE

Position Statement

915 Lee Street, Des Plaines, IL 60016-6569 ▪ 800.900.9659 ▪ www.ena.org

Emergency Nursing Interface with Mobile Integrated Health (MIH) and Community Paramedicine (CP) Programs

Description

Emergency departments (ED) provide a substantial proportion of the healthcare delivered in the United States.[1] Increased ED utilization is a reflection of increasing community healthcare needs and the lack of access to available care.[1,2] Indeed, a recent literature review found that on average, 37% (range 8–62%) of patients seeking emergency care were triaged with the lowest rating of non-urgent.[3] With ever-increasing numbers of patients, emergency departments face significant barriers to the delivery of acute care and essential healthcare services.[2,4] Inappropriate use of emergency services, crowding, frequent "bounce-back" visits, barriers to access of care, and fragmentation in care all strain emergency departments, which serve as the safety net of the US healthcare system.[4] These inefficiencies are more than an economic problem: they have a human toll and lead to suffering and unnecessary deaths.[4]

The Institute for Healthcare Improvement has proposed the following three-pronged approach to the problem:

- Improve the experience of care
- Improve the health of populations
- Reduce the per capita costs of healthcare[5]

Achieving these aims will require communitywide partnerships among prehospital, particularly EMS, and community professionals including social service providers, behavioral health professionals, and educational leaders to provide an effective approach.

In 2013, citing wasteful spending, unnecessary services, inefficiently delivered services and missed prevention opportunities, the Institute of Medicine (IOM) recommended a "system wide transformation" to include engaging patients, embracing new technologies, increasing teamwork and transparency, and valuing outcomes of care.[4, pg. 320]

One innovative strategy, Mobile Integrated Healthcare (MIH), is being piloted or has been implemented across the United States. This population-based healthcare delivery approach uses out-of-hospital resources in the community setting to provide services to a wide range of patients within a given population. Community paramedicine (CP), an example of MIH, allows paramedics and emergency medical technicians (EMTs) to operate in expanded roles within their scope of practice in the field under the direction of a physician.[6,7] These programs were originally implemented to increase access to healthcare in underserved rural areas.[8] In 1996, the US Department of Transportation *Emergency Medical Services (EMS) Agenda for the Future* outlined a plan for EMS to integrate primary care services into the community.[9] In 2012, there was a proposal for further expansion of the EMS role into non-rural areas.[8]

In many cases, CP programs are filling a gap in services that had been performed by public health nurses and visiting nurses.[7] This raises uncertainty related to overlapping responsibilities, education and training,[7] and underscores the necessity for interprofessional collaboration and role clarity.[10–14] Currently, it is the registered nurse who coordinates discharge planning, referrals for chronic disease management, post-discharge community follow-up, and continuing preventive care.[7] In fact, the American Nurses Association cited their belief that "patient-centered care coordination is a core professional standard and competency for all registered nursing practice" presents a major motivation for establishing interprofessional collaboration[7,pg.1] and advocate communication and cooperation between paramedics and registered nurses.[7]

The intended expansion of the community paramedic role may overlap emergency nursing scope of practice, education and training.[15] Thus, collaboratively developed MIH and CP frameworks with clearly-defined roles are essential as these programs move forward in providing specific needs-based community resources. /.[8,10–14]

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ENA Position

It is the position of the Emergency Nurses Association that:

1. Emergency nurses support all members of the healthcare team to function fully and collaboratively, consistent with their education, training, and scope of practice
2. Emergency nurses promote and support public health services that provide safe, patient-centered, quality care
3. Emergency nurses collaborate with a variety of interprofessionals to improve the health of populations served, reduce healthcare costs, and improve individual patient experiences
4. Interprofessional teams with members having clearly defined roles are essential to provide patient care within the framework of MIH and CP programs
5. Patient-centered care coordination is a core professional standard and competency for all registered nursing practice
6. Emergency nurses support advanced education for EMS providers in MIH and CP programs
7. Emergency nurses advocate for additional research to measure the efficacy of these community programs

Background

Pioneering programs such as the MIH and CP have launched a movement for more cost-effective healthcare spending using a patient-centered approach integrated with a team-based, interprofessional collaborative structure.[10–13] Services offered by these programs include telephone triage, chronic disease management, follow-up home visits, post-discharge education, and preventive care, all under medical direction or oversight.[16–20] These programs may present an opportunity to increase the proportion of individuals who have access to care.[8] In fact, current data show they may help prevent hospital readmissions and reduce ED visits by decreasing the number of frequent-user transports.[8]

These programs face challenges.[21] Many states have well-established MIH or CP programs, whereas others have only recently amended their EMS laws to legalize and support these programs.[10] States without legislation in place regarding these programs create regulatory challenges and barriers including uncertainty over funding and reimbursement[21] requiring these programs to be locally funded.[22] The role of the community paramedic is subject to state regulations and certification [6,7,10–14, 23] creating a regulatory barrier since many states require every patient be transported.[8] There is also inconsistency among programs regarding education, scope of practice and physician oversight.[21] Some programs call for advanced EMS training while others use EMS providers at all levels without additional training.[8] Advanced education for paramedics usually includes diagnostic and triage skills, expanded psychomotor skills, and pathophysiology of chronic disease.[8]

In 2014 the National EMS Advisory Committee (NEMSAC) published their final advisory on community paramedicine.[21] They outlined multiple recommendations and strategies regarding the provision of healthcare services and urged a national healthcare stakeholder strategy meeting to guide the implementation of these programs.[21] Successful program strategies recommend completing an assessment of a community's healthcare needs to identify populations who might benefit from MIH and CP programs. [6,8,10] Emergency nurses, together with discharge planners, case managers, social service providers, emergency nurse practitioners and emergency physicians will be essential for identifying patients at risk and providing education. Further role clarification and collaboration will also be necessary to determine how contact information and community referrals will be disseminated. Opportunity exists for emergency nursing collaboration with EMS and other interprofessional colleagues to clarify roles and maintain the integrity of registered nursing scope of practice as ED patients are transitioned into these community programs.

While there is much in the literature regarding MIH and CP, there are currently few studies to support the efficacy, safety and economic benefit of these programs.[8] Additional studies are necessary to validate preliminary findings and provide evidence-based performance measures.[8]

Resources

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