



# Position Statement

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

### Description

Emergency medical services (EMS) and emergency care settings (ECS) continue to provide primary care services to a substantial and disproportionate percentage of the healthcare population in the United States.<sup>1</sup> In fact, Medicare conservatively estimates that 16% of all emergent ambulance transports are not necessary and that treatment could have been provided outside of the ECS.<sup>2</sup> Misuse of EMS for primary care services is expensive and inefficient and is linked to ED overcrowding, frequent return visits, barriers to accessing care, fragmented care, poor patient and population health, and unnecessary suffering and death.<sup>1-3</sup>

In response, mobile integrated health and community paramedicine (MIH-CP) programs have been integrated into many communities' care networks.<sup>1-3</sup> This has been done to align patients with appropriate care outside of the emergency arena, as well as to capitalize on MIH-CP programs' skill of personnel, familiarity with patients in the community, and mobile capability.<sup>1-4</sup> MIH is defined as care provided by a wide array of healthcare entities and practitioners that are administratively or clinically integrated with EMS agencies.<sup>5</sup> Other healthcare partnerships with MIH-CP programs include community-wide collaboration amongst patient representation and prehospital services, as well as industry professionals such as emergency nurses, nurse practitioners, medical staff, pharmacists, social workers, behavioral health professionals, and educational leaders.<sup>2-6</sup> CP is defined as care provided by state licensed or credentialed EMS professionals who have completed an appropriate educational program and have demonstrated competence in the provisions of health education, monitoring, and services beyond their traditional roles of emergency care and transport.<sup>7-9</sup> MIH-CP is a rapidly evolving care model defined by the Agency for Healthcare Research and Quality (AHRQ) as the provision of healthcare using patient-focused, mobile resources in the out-of-hospital environment.<sup>9</sup> It may include:

- Increasing access to care in underserved areas
- Providing telephone advice to 911 callers instead of dispatching resources
- Using CP for management of individuals who frequently request health service or patients at risk for hospital admission or readmission, chronic disease management, preventive care, or post discharge follow-up visits
- Transport or referral of patients to a broad spectrum of appropriate care, not limited to hospital emergency departments.

As these programs continue to evolve so do opportunities for increased interprofessional collaboration between emergency nurses and MIH-CP programs. Emergency nurses are adept at coordinating discharge planning, referring for chronic disease management, initiating post-discharge community follow-up, and conducting continuing preventive care.<sup>10</sup> In this regard, collaboration of emergency



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nurses and MIH-CP can improve communication and cooperation between disciplines and enhance care services in ways that meet patient need.<sup>7-12</sup> This could also provide clarity regarding services and common goals; support for education, training, and accountability; and the development of synergistic services.<sup>7-14</sup>

Collaboratively developed MIH-CP frameworks with interprofessional partnerships are essential to providing comprehensive community healthcare resources.<sup>2,3,5-8,10-15</sup>

## ENA Position

It is the position of the Emergency Nurses Association (ENA) that:

1. Emergency nurses support all members of the healthcare team in functioning 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 providing patient care within the framework of MIH-CP programs.
5. Emergency nurses support focused education for EMS providers in MIH-CP programs.
6. Emergency nurses advocate for additional research to measure the efficacy of MIH-CP programs.

## Background

Each ED visit used in place of a primary care visit is four times more costly to persons and payer sources (\$1,045 versus \$248), and ED misuse accounts for about \$38 billion a year.<sup>2</sup> Combating this financial waste, MIH-CP programs were formed to reduce healthcare cost.<sup>2,4,6,13-15</sup> Aiding the development of these programs were the roles EMS already played within our communities and their ability to meet patients in their own environments.<sup>2</sup> EMS agencies had previously established medical direction, the necessary means and equipment, and organizational and operational infrastructures to reach patients in the out-of-hospital environment.<sup>2,6,13-15</sup>

Given that there is great potential to reduce healthcare spending and improve outcomes by reducing unnecessary EMS and ECS use, MIH-CP programs are a recognized component of healthcare



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reform.<sup>2,4,9,11</sup> Current literature demonstrates outcome-focused strategies with MIH-CP in interprofessional teams in collaborative structures.<sup>2,9,11-15</sup> As such, MIH-CP services now extend beyond primary care support to include additional roles such as behavioral health assistance, disaster readiness and response, nurse practitioner roles, geriatric care, homeless care, and reduction of high utilization of EMS and ECS resources.<sup>2,6-24</sup> These additional roles improve community care services, encourage proper use of healthcare resources, and facilitate the development of strategies for future state planning and analysis.<sup>16-25</sup>

In 2017 the National EMS Advisory Committee (NEMSAC) published their final advisory on MIH-CP.<sup>26</sup> They acknowledge CP as a true profession and give credence to their worth in community care.<sup>26</sup> They also outlined multiple recommendations and strategies regarding the provisions of MIH-CP services, and they continue to urge national stakeholder meetings to guide community implementation processes.<sup>26</sup> Lastly, NEMSAC recognized the necessity of continued MIH-CP program assessments. Current program standards include social determinants of health, community assessments, public health and epidemiology, diagnostic and triage skills, expanded psychomotor skills, environmental assessments, and pathophysiology and management of chronic disease.<sup>2,3,7,9,11,26</sup>

Although MIH-CP programs are showing to be successful in meeting their goal of reducing preventable ED visits, some programs have faced challenges in their inception.<sup>1,9,11</sup> This may be due to inadequate collaboration or community needs assessments.<sup>11,22</sup> Lack of professional collaboration or adequate needs assessments has resulted in programs not connecting with patients in a meaningful way.<sup>11,19,22</sup> Collaboration with patients, emergency nurses, discharge planners, case managers, social services providers, emergency nurse practitioners, and emergency physicians is essential for and contributes to MIH-CP program success.

## Resources

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